A management process workshop for head nurses with more than two years experience in a management role

by
Pamela L. Smith

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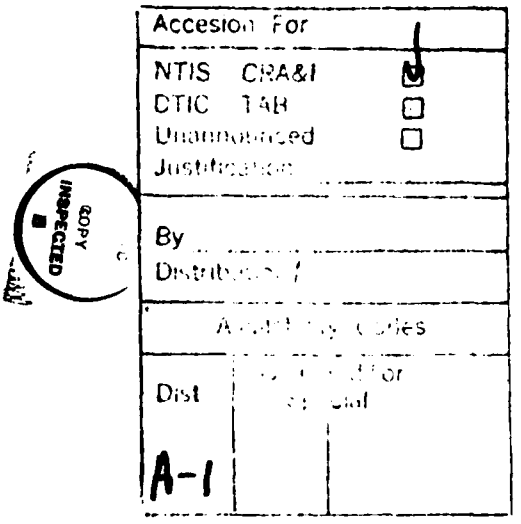

Introduction

Nurse-managers are appointed to positions of authority, direct the work of others, have a responsibility for resource utilization in the provision of patient care and are accountable for the results. These tasks are accomplished through the management process which involves the functions of planning, organizing, staffing, directing and controlling. Successful nurse-managers will be those who understand and incorporate the management process into their daily activities.

Understanding is derived from knowledge and education. The American Nurses Association believes "continuing education is essential for maintaining competence in nursing practice. It is necessary for personal growth and professional maturity." Nurses at every level need continuing information and education to practice with effectiveness and efficiency.

The author noted there were no management related continuing educational events for experienced charge nurses at Air Force facilities where she's been assigned. The nursing administration staff at the civilian health care facility where the author completed a management residency also identified a need for continuing education in management for their experienced head nurses.

This thesis option project was developed in response to the previously identified needs. It consists of a curriculum for a management process workshop for experienced first-line nurse managers. This workshop can be utilized in both Air Force health care facilities and the civilian institution of the author's management residency. The organizational framework for the workshop will consist of the five functions of management as they relate to the experienced first-line nurse manager.

The planning function deals with the present and anticipates the future. It answers the questions of what to do, when, who and how. It involves developing forecasts, missions, goals, objectives, strategies and operational programs.

The organizing function establishes authority and responsibility relationships. Communication skills are required of the nurse manager for team building and coordination of the work flow process on the patient care unit and in committee situations.

The staffing function is associated with activities to acquire and retain human resources. This encompasses man-power planning plus staff development through role modeling and mentoring.

The directing function focuses on initiating action which results in a change. Accomplishing work through people is the objective necessitating the nurse manager to possess knowledge and skills in change theory, delegation and negotiation.

The fifth management function is controlling. Its focus is the monitering of the quality of patient care through the establishment of standards the use of measuring and evaluation tools. Monitoring responsibilities encompass budgetary, resource utilization and patient/consumer concerns.

Decision-making is an essential process or activity common to all five management functions, therefore this continuing education workshop will begin with a presentation of decision-making concepts.

The author incorporated adult learning theory in the development of this educational activity. Educational experiences for nurses should utilize theories of adult learning" (ANA, 1979, p. v). Puetz states (1987, p. 54) that continuing education activities are to be focused on adult learners rather than the teachers. Cross (1981, p. 78) asserts that continuing education classes consist virtually of 100% working adults and must be sensitive to adult learning theory (ALT) needs.

Adult learning theory

This section summarizes the author's research in adult learning theory (ALT). The contents include a definition of an adult, a discussion of how and why adults learn and application of the principles of ALT to the adult educator's role in a continuing education setting.

Defining an adult

The target audiences of adult learning theorists and adult educators are determined by defining what constitutes an adult. Webster's New Collegiate Dictionary (1976, p. 17) categorizes an adult as "fully developed and mature: grown-up, a human being after an age specified by law." Malcom Knowle's definition is more concrete, therefore easier to apply. An adult is an individual performing roles typically assigned by a culture to those it considers adults and those whom perceive self as essentially responsible for their own life (1980, p. 24).

How adults learn

There has been extensive research regarding the methodologies adults utilize in the learning process. One theory derives from the anatomical make-up of the human brain. The cerebrum is divided into right and left hemispheres. The left hemisphere contains the center for language skills, speech, rationalization, deduction, logic, sequencing and reasoning. The right hemisphere contains centers for visual-spacial skills, emotions, abstract patterning, thinking, intuition, artistry and creativity (Peters & Waterman, 1982, pp. 55 & 59-60 & Eagleton, 1989).

Most individuals have a dominate hemisphere which determines the primary and most efficient way they learn. Eagleton's research (1989) indicates there are three sensory modalities for information processing and information recall. An individual who processes and remembers information pictorially plus uses phrases such as I get the picture or It's clear to me is principally a visual (right brain) learner. An auditory (left brain) learner processes information most effectively by hearing it and recalls data using such phrases as I hear what you're saying or That rings a bell. The third learning methodology is kinesthetic (right brain). Information is processed through feelings, touch and body sensations. Data is recalled

with phrases similar to I'm not comfortable with that, I grasp what you're saying or that's touching.

Knowles' theory of adult learning leaves the physiological arena for the arenas of psychology and environment. He determined children and adults learn differently. Knowles' research led to the andragogical model of learning which includes the following assumptions:

1. Adults learn when a need exists. They must know why they need to learn before they will undertake learning.
2. Adults learn when they are allowed to be self-directing. An adult's self-concept is equated with independence or responsibility for decisions and their own lives.
3. Adults learn and derive an identity from their experiences. They enter into educational activities with varied experiences that can be tapped using case studies, role play or discussions. Ignoring or rejecting their experiences is equated with rejecting and ignoring the individual. Experiences may also be reflected as biases, habits and closed minds to new ideas and learning.
4. Adults are ready to learn when, what they need to know can be utilized to cope effectively with real-life situations. They learn what is perceived will help them perform tasks or problem solve.
5. Adults respond to external motivators, however internal pressures (self-esteem, job satisfaction, quality of life) are their most potent motivators (1984, pp. 55-61).

Knowles also discovered learning is facilitated when an adult's desires of respect for personality, participation in decision-making, freedom of expression and availability of information along with mutuality of responsibility in diagnosing needs, setting goals, planning, conducting and evaluating learning activities is recognized and incorporated into the learning process (1980, pp. 44-45 & 1984, pp. 97 & 116).

"Climate is the most important aspect of human development" (Knowles, 1984, p. 118). The physical environment should be comfortable in respect to light, temperature, acoustics, restrooms and refreshments. The interpersonal climate should approve and reward new behaviors, encourage behavior maintenance and allow for behavior practice. The psychological climate should convey orderliness, clearly defined goals, a careful explanation of expectations and opportunities, an

openness of the system to inspection and questions plus honest objective feedback. It should also encourage experimentation while being tolerant of mistakes.

Cross has identified four patterns of learning in adults.

1. Cognitive: Learning is a function of aging. Reaction time, vision and hearing are the most likely physical changes to interfere with learning. Intellectual functions involve the ability to learn. They are affected by heredity, experience and knowledge. On the average people perform best in youth on tasks requiring short-term memorization and complex interactions. As aging occurs knowledge is accumulated and a perspective is developed for its application. Older adults are capable of learning, but at a slower pace.

2. Adult development: The older adult shows more task orientation and a desire to do right with a reluctance to suffer a blow to esteem thus there is less risk-taking. The experienced adult can operate with greater skill and deliberation, more efficiency and less time wasted with trial and error. There's also increased individualism with aging and dependence on previously learned solutions.

3. Self-directed: The objective is to gain and retain specific knowledge, skills or other changes in self. Learning is self-planned and pursued. One decides which learning activity to attend and which objectives to glean from the program. Learners do want help with planning and guiding their projects. Cross (p. 30) sees almost all professionals as self-directed learners.

4. Group learning: The planning and decision-making is often by the instructor, thus the learning experience frequently is not satisfactory to adults.

The tasks of building vocabulary, generalizing information and dealing with ideas improves during most of adult life, but rote memory discovering figural mathematical relations and inductive reasoning steadily decline (Knox, 1986, p. 21). Knox sees adults as changing from unquestioning conformity to recognizing multiple viewpoints to independent thinking. At the same time conceptualization styles change from functional relationships to analysis to inferentializing (1986, pp. 22-23). Knox (1986) identifies four developmental changes:

1. Fragmentary understanding: Facts and details are processed superficially without central concepts

identified. Problem solving and information processing are fragmentary.

2. Comprehension: Central concepts are understood, but without the relationships to supporting ideas or facts being identified.

3. Understanding relationships: Facts and details are integrated with concepts and themes.

4. Inclusive learning: It goes beyond the context of presented information integrating themes, using experiences and knowledge to look for reasons, identifying similarities and differences among concepts plus exploring alternative views for the development of new insights (pp. 9 & 154).

There are five levels of activities within which learning occurs (Knox, 1986, pp. 85-91).

1. Individual: Each student interacts with the instructor, but not with each other. The emphasis is on the individual and self-directedness. Teaching is by coaching, demonstration, computer assisted instruction, correspondence, reading and tutoring.

2. Large groups: The emphasis is first on the presentation of ideas then relating them to current situations. Teaching methods include lecture, panels, debates and subgroup discussions.

3. Small groups: The emphasis is on the analysis of ideas with teaching accomplished through discussion, seminars, case presentation and analysis, in-basket exercises, games and demonstrations.

4. Organizational: The emphasis is on studying one's organization and team building. The teaching method involves planning and implementing an organizational project.

5. Community: The emphasis is on broadening one's horizons and community involvement. Teaching encompasses field trips plus community surveys and projects.

These levels take into account three categories of learning instruction: pure instruction where didactic presentations occur, inquiry where the participants seek answers and performance where learned knowledge is put too use (Knox, 1986, p. 95).(1981, pp. 154-199).

Learning has been described as a domain change in response to the environment (Van Hoozer et al., 1987, pp. 21-28). The three domains of learning were described by Bloom in 1956 (pp. 6-7). The first domain, psychomotor, involves skill and coordination development. It requires reinforcement and repetition. Affective is the second domain and consists of

attitudes, values, motivations, opinions and feelings. It predisposes one to an action or method of adjustment. The third domain is cognitive and includes knowledge, facts, principles, concepts, comprehension, synthesis, application and evaluation skills.

The author will briefly discuss three additional learning related theories. The first is Humanistic (Cross, 1986, p. 228 & Van Hoozer et al., 1987, p. 8) which assumes a natural tendency for learning that will flourish if nurturing encouraging environments are provided. The learners are helped to think through what and how they'd like to learn without the facilitator making value judgments. Learning is seen as the full development of cognitive, affective and psychomotor potential. This equates with Maslow's goal of self-actualization (Maslow, 1954, pp. 80-97) that man strives toward.

Developmental theorist's (Cross, 1981, p. 239) view each stage of learning/development as part of an integrated whole. One stage is integrated into the next stage and replaced by it. Each individual acts out their own synthesis and must pass through one stage prior to moving on to the next stage. The stage order is universal and constant. Learning experiences should be challenging and stimulating as compared to the acceptance and encouragement philosophy of learning held by humanists.

The final theory for discussion is the Gestalt-Field theory which notes learning is an active process between the learner and the environment (Van Hoozer et al., 1987, pp. 6-7). Learning is dependent on what the learner does, thinks, feels and requires. One acts or reacts to a perception of the situation. Perception is selective and individual due to heredity, socio-cultural background, experiences, understanding, interpretation, skills, values and attitudes. Learning is enhanced when this uniqueness is considered in the planning and delivery of an educational activity.

Adults have characteristic ways of processing information and preferences about how they'd like to learn (Puetz, 1987, p. 89). Learning usually involves a blend of the four process modes with one blend being a preferred learning style (Kolb, 1971) & Puetz, 1987, pp. 90-92) for an individual.

1. Concrete experience mode: Experience is the basis of learning. There's people orientation and a reliance on feelings for judgments.

2. Abstract conceptualization mode: Analytical learners prefer logical thinking in an authority directed situation with the focus on theory and systematic analysis of concepts.

3. Active experimentation mode: The orientation to learning is doing. The learners are extraverted and want to be actively involved in learning.

4. Reflective observation mode: These learners are more tentative and deliberate. They rely on examination and introspection before making judgments and are relatively passive in learning situations.

a. Converger blend: These learners prefer practical application of ideas, things over people and tend to have narrow highly technical interests. They process a large amount of information to obtain one answer. They learn well with case studies, applied research and field problems.

b. Diverger blend: These individuals excel in imaginative ability and view concrete situations from many perspectives. They're interested in people and are emotional with broad cultural interests. They're creative thinkers and do best with learning situations that can be expanded to all possibilities. Learning is facilitated by discussion groups as they are talkers.

c. Assimilator blend: These students are most effective in creating theoretical models and combining different observations into a congruent whole. They're interested in abstractions, but not practical applications and tend not to be people oriented. These learners are good at theory building and excel at putting the big picture together. They learn best using observation and thinking skills in pure research, reading or lecture situations.

d. Accomodator blend: These learners are effective in doing things, carrying out plans and like new experiences. They are risk takers, adaptive, and interested in people, but may be impatient and pushy. As learners they like to combine facts and action and enjoy role-play, simulation and games.

Individuals also use their senses for learning. For all learners visual memory tends to be greater than auditory (O'Connor, 1986, p. 127). Garcia's memory related research resulted in an adaptation of Edgar Dale's Cone of Experience. People generally remember 10% of what's read, 20% of what's heard, 30% of what's seen, 50% of what's seen and heard, 70% of what's said and written by them and 90% of what's said and done.

Van Hoozer et al. find learning is facilitated with active overt short periods of practice and periods of rest followed by behavior reinforcement and constructive feed-back (1987, p. 45). Learners have a preference for passive or active involvement, a quick pace or lingering exploration of concepts and prefer either learning in a group or a solitary setting (O'Connor, 1986, p. 127).

Van Hoozer et al. (1987, p. 45-47) found adults have some rigidity in thought and action due to their experiences. Learning is resisted if it is seen as an attack on the learner's competence. Learners fear external judgements and failure therefore they have anxiety in learning situations. They dislike jargon preferring plain simple language.

King (1986, pp. 22-24) notes that learning is an individual activity; no one person can learn for another. When something is valued transactions occur to reach goals.

Why adults learn

Knox's (1986) research led to his proficiency theory of adult learning. Adult development is a prompt for learning (p. 21). Learning occurs to enhance proficiencies for the mastery of developmental tasks. Adults identify deficiencies or gaps between their current and desired proficiencies. Learning is undertaken to enable the gaps to close. Proficiencies are related to developmental changes involved with life-time maturation. Knox (1986, pp. 16 & 220) believes it is important for an educator to understand the tasks associated with the evolving developmental changes leading to maturity. A teacher is then better able to assess educational needs, guide learning activities, evaluate progress, enhance a sense of proficiency achievement and stimulate learning.

Knox (1986, pp. 24-25) determined education is first for practical benefits, then for occupational advancement. It helps with personal coping, growth to self-forfillment, autonomy and self-actualization. He also felt (p. 28) the purpose of continuing education is for assisting adults with life's roles and responsibilities. Role change events require adaptation and change which comes from learning.

Cross (1981, p. 240) states the greatest opportunities and motivation for learning occur at life's transition points and developmental stages. Cross (1981, pp. 174-175), Havighurst (1961, pp. 72-98)

Knowles (1980, p. 51) and Knox (1986, pp. 26-28) described categories of developmental stages where role change is required. The author has integrated and summarized their research into five categories.

1. Adolescence to young adult (13-18): The basics are learned. There's general conformity with peers followed by specialization and generalization.

2. Early adult (18-30): Regard self as an adult. There is marriage, establishment of a home, start of a family, build a dream, get hired, fired or quit a job then find an occupation, a mentor and a congenial social group, plus assumption of civic responsibilities as a committee member. Enrollment in educational activities is related to occupational advancement/specialization, marriage and family or management of home finances.

3. Adult (30-40): Search for stability, security, control and personal values. Women experiencing an "empty nest" may turn to education and a career. There is a reassessing of personal values and priorities, setting of long-term goals, a crucial promotion, a break with one's mentor, consideration of a career change in addition to establishing and maintaining economic standard of living. Teenagers are assisted with becoming happy and responsible adults. Major civic contributions are made while adjustment to biological changes occurs. Educational activities are related to career advancement, supervision, mid-career changes and marriage enrichment or divorce.

4. Adult (40-55): Adjust to developing physical limitations and aging parents. There is a settling down with development of leisure activities, an awareness of self and one's competence leading to becoming a mentor and capping a career. Education focuses on executive development, human relations, social issues, stress management and preparation for retirement.

5. Late adult (55-death): There is comfort with self, a review of one's life, adjustments to decreased physical strength and health, begin to think about death with the family being important. Establishment of satisfactory living arrangements and affiliation with one's age group occurs in conjunction with retirement and lessened income. Social and civic obligations are achieved along with coping with a spouses death.

Knowles (1980) notes learning is also brought about by an accelerated changing world and one must

keep up with education in order to survive. He identifies incentives for adult learning including seeking praise, prestige and pride from accomplishment, social or business advancement plus to improve self-confidence enjoyment and comfort (p.19).

Knowles also believes motivation for learning relates to the need to develop from immaturity to maturity as outlined by Harry Overstreet's Dimensions of Maturation.

Immaturity	Maturity
Dependency	Autonomy
Passivity	Activity
Subjectivity	Objectivity
Ignorance	Enlightenment
Small abilities	Large abilities
Few responsibilities	Many responsibilities
Narrow interests	Broad interests
Selfishness	Altruism
Self rejection	Self acceptance
Amorphous identity	Integrated self identity
Focus on particulars	Focus on principles
Superficial concerns	Deep concerns
Imitation	Originality
Need for certainty	Tolerant of ambiguity
Impulsiveness	Rationality

Every educational activity provides for adult growth or maturity in several of the previously listed dimensions (Knowles, 1980, pp. 28-32 & Overstreet, 1949, p. 43).

Knowles relates Lorge's and Overstreet's assertions to Lorge's four premises of motivations for learning.

1. People want to gain health, time, money, popularity, improved appearance and security in old age.

2. People want to be good parents, social, hospitable, up-to-date, creative, proud of their possessions, influential, efficient, gregarious, first and recognized as an authority.

3. People want to (do) express their personality, resist domination, satisfy curiosity, emulate the admired, appreciate beauty, acquire/collect things, win other's affections and improve themselves.

4. People want to save time, money, work, discomfort, doubt, risk, and personal embarrassment (Knowles, 1980, p. 89 & Lorge, 1947, p. 25).

Learning motivation also arises from the institution one's associated with. The administration

may seek development of the individual in the direction of the organization's goals for the individual, for improvement of the institution and for the development of public understanding and involvement (Knowles, 1980, p. 33).

Cross researched adult learning and found in most studies between 1965 and 1980 over half of the respondents state they are in a learning activity in order to seek a new job, advance in the present job or to obtain a better job. Factors stimulating job related educational activities include job obsolescence secondary to technological or societal changes, the changing roles of women in the labor market, increased longevity and activity in the work force, job competition, higher aspirations, social acceptance of a career change and potability of pension plans. Learning is also related to recreational and leisure needs, but primarily among the affluent and well educated populous (1981, pp. 20-22).

Adults desires to learn are based partially on past successful or unsuccessful experiences (Clark, 1979, p. 42). Feed-back indicating mastery of new skills or concepts (successes) motivated the student to continue a learning activity (Puetz, 1987, p. 116). Humor also motivates adults, they like to laugh. When learning is fun it is more interesting (Puetz, 1987, p. 114).

Cross (1981, pp. 82-83) agrees with Houle's (1961, p. 15-19) findings on three motivations for adult learners. The first motivator is goal orientation where learning occurs to gain specific objectives. The second motivator is activity orientation when the learners participate in education for the sake of the activity itself, rather than the subject matter. Learning situations are thus utilized to cope with loneliness, boredom, an unhappy home, to uphold a family tradition and to amass credits. Learning orientation is the third motivator where learning is pursued for its own sake. The learner has desires to know and to grow. An adult educator must not only understand how and why adults learn, but also must be able to apply this knowledge in practice.

<u>The adult educator's roles</u>

The traditional teacher's role has been an authoritarian individual who determined the curriculum taught and its goals. Currently the teacher's role is to serve the adult learner's needs (Cross, 1981, p.

34). Knowles (1980, p. 18) feels the educator's mission is to produce competent people who are able to apply knowledge under changing conditions. He describes the adult educator's functions as:

1. Diagnosing: help learners diagnose their needs for particular learning within the scope of a given situation.
2. Planning: plans with the learners sequences of activities to produce desired learning.
3. Motivating: creates conditions causing learners to want to learn.
4. Methodological: selects the most desired methods and techniques to produce desired learning.
5. Resource: provides resources needed for learning.
6. Evaluation: helps learners measure outcomes of the learning experiences.

An adult educator is a change agent with roles including helper, guide and consultant who views clients as important (Knowles, 1980, p. 37). When adult learners are entirely dependent on the teacher for learning materials a pedagogical (child) approach should initially be utilized in presenting learning materials. As the new materials and concepts are grasped the educator moves to an andragogical (adult) teaching approach (Knowles, 1984, p. 62). Knowles integrates the role of an andragogical teacher with seven learning condition (1984, pp. 83-85) and their associated teaching principles.

1. Learners need to feel a need to learn.

a. Exposes students to new possibilities, helps them clarify aspirations, diagnose gaps between current knowledge and aspirations and to identify problems due to knowledge gaps.

2. The environment should convey mutual trust and respect, helpfulness, freedom of expression, acceptance of differences and physical comfort.

b. Respects feelings and ideas, builds trust and helpfulness by encouraging cooperative activities, refrains from inducing competitiveness and judgement, accepts each student as worthy, exposes own feelings, conveys learning as mutual inquiry, and provides for physical comforts.

3. Learners perceive activity goals as their own.

c. Involves students in objective formation.

4. The learner accepts a share of the responsibility for the learning experience producing increased learner commitment.

d. Shares options available, involves students in decision-making.

5. Learners participate actively.

e. Helps students organize.

6. The learning process is related to and utilizes the learner's experiences.

f. Helps students exploit their experiences as resources, gears presentations to the student's level and helps students apply new learning.

7. Learners have a sense of progress towards goals.

g. Involves students in developing criteria for progress measures, helps students apply measures for self-evaluation.

The educator's effectiveness in engaging adult learners depends on their understanding of the learner's motivations and unmet needs (Knox, 1986, p. 128). Knox (1986) sees the role of an adult educator as responding to the learner's needs (p. 95), to enhance proficiencies (p. 5), to help learners increase their independence in learning allowing for self-pacing, facilitating participant's interactions, provide clear explanations of complex materials using memorable examples and to assist with program review (p. 109).

The most valuable information for helping adults learn/change is knowledge about their current proficiencies (knowledge, attitudes, skills). This process equates with a needs assessment. An educator's role encompasses being a change agent (Van Hoozer et al., 1987, p. 48). Needs are identified and a plan for change developed from an assessment of the learner's needs and their goals and of self (knowledge-goals-teaching style) plus the resources available. This aids a teacher in planning and structuring the most optimal learning conditions and climate possible. Information about learners allows an instructor to relate new materials and ideas to the student's current knowledge base, interests, attitudes and aspirations (Knox, 1986, p. 79).

A needs assessment involves the institution an individual is associated with when the new knowledge will be utilized on the job (Knox, 1986, p. 79). The organization's size, mission, goals and resources are evaluated and integrated into the educational activity.

A teacher's responsiveness to the learner is indicated when the teacher shows respect for the learner's current proficiencies and preferred learning

style (Knox, 1986, p. 53). In most continuing education settings the instructor is unable to diagnose individual learning preferences due to the cost and time required. Educators should use knowledge of ALT, incorporating a variety of teaching methods to accommodate a group's diverse learning preferences (Puetz, 1987, p. 92) and multiple reasons for engaging in a learning activity.

Adults don't like to be singled out of a group, thus teachers should seek volunteers (Puetz, 1987, p. 116). Expert learners, nurses, do not like an argumentative or lecturing instructor. They tend to resist change that new learning requires, but possess an ability to change that's directly proportional to their degree of comfort in the educational setting (Clark, 1979, p. 41). The educator establishes both the physical and psychological climate. Clark's (1979, pp. 42 & 48), Knox's (1986, pp. 48 & 132-134), Knowles' (1980, p. 46 & 1984, p. 121) and Puetz's (1987, p. 108) descriptions of environments fostering successful learning experiences are summarized by the author.

The climate is often set by the methods used to introduce the presenters and the way learners are greeted and subsequently treated; do they feel included or ignored by the educators? The facilities should be attractive. Lecterns convey formality, while tables convey informality, participation and collaboration. A comfortable room temperature and near-by restrooms are important considerations in selecting the learning facility.

Warm-up activities assist participants in getting to know each other and can establish the atmosphere as challenging, yet supportive and friendly. Adults prefer friendly informal climates where they are called by name, valued as unique individuals and can be self-directing plus self-evaluating. A challenging climate occurs when the learning program is problem centered in addition to being neither boring or threatening.

Carefully prepared questions can guide the learning process, challenge, draw out reticent students, broaden discussions, elicit multiple viewpoints and minimize anxiety. Questions can also encourage sharing, arouse interest and assess understanding. The educator must provide time for students to answer acknowledging the learners in a positive manner. Questions allow adults to be active participants in the learning and the evaluation processes of an educational program.

The educator's role includes program evaluation (Knox, 1986, p. 186). Evaluation addresses audience issues. It begins with the participant's reactions to the program and their test results. Evaluation is valued for its input into the improvement of current programs, the justification of a program's existence and for providing ideas for future program planning.

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Section II

Management Process Workshop

Purpose
Audience
Content
Format
Curriculum

Purpose

This workshop is designed to provide information enabling seasoned nurse managers to incorporate the management process into their daily practice.

Audience

The proposed participants are experienced nurse-managers who have two or more years experience in a management role, accountable for a patient care unit. Its anticipated the attendees would not have a master's degree in administration since (some) similar concepts will be presented. However, this workshop could benefit administratively prepared nurses as it provides a review and application of selected management principles utilized in daily practice.

The workshop is also appropriate for master's prepared clinical specialists, whose course work often provides minimal exposure to the management process. This workshop will furnish a means for practical application of management principles. These principles can be used by clinical specialists as they collaborate in decision-making, planning, organizing, staffing, directing and controlling patient care activities.

The predicted highest levels of education for an Air Force audience of charge nurses are: 95% or more will have a BSN, while 5-10% will have a MS or a MSN. The civilian institution this workshop was also designed for currently has 23 head nurses. Their highest levels of education are: Diploma (2) 9%, ADN (6) 26%, BS (1) 4%, BSN (12) 52%, MA (1) 4%, and MSN (1) 4%.

A prerequisite for an Air Force charge nurse's attendance at this workshop is completeion of Nursing Service Management either by correspondence or in residence. The prerequisite for a civilian head nurse's workshop attendance is completion of the Nursing Management series part 1: CN role - entry level management and part 2: Aspiring or new managers or completion of a similiar program.

Content

The workshop's organizational framework encompasses the five management functions of: planning, organizing, staffing, directing and controlling. Decision-making skills are required for accomplishing each of these functions, therefore decision-making concepts will also be presented. The curriculum content will consist of objectives, teaching

helps, lecture material, exercises and references to facilitate the learning process. The participants will be asked to evaluate the workshop at its conclusion.

Format

The workshop is divided into six topic areas: introduction and decision-making, planning, organizing, staffing, directing and controlling. Three hours is the estimated time-frame for each section. This includes time for discussion, lecture and breaks (two 10 minute breaks or one 20 minute break).

This workshop includes practical information for use on the job. It is recommended each session be scheduled either once a week or every other week. This would enable the participants to take information back to the work setting, use it in their practice and have an opportunity to discuss theory application at the next workshop session.

Breaks between sessions facilitate student preparation (ie. reading, identifying positive and negative experiences and concerns for discussion) regarding the up-comming class. Participants will receive a reference list and suggested readings will be identified. Breaks also allow the educator to research answers to participants questions and to revise lecture materials in order for the information to be useful to the learners.

Welcome and Introduction

I am .... and my backgroung is .... I'd now like to take 15-20 minutes for everyone to introduce themselves, identify your area or responsibility or specialization and state one or two expectations you have of this workshop that you'd like to take back to your area of practice. This will help me to address some of your specific needs and concerns during this presentation.

As nurse-managers you are appointed to positions of authority, direct the work of others, have a responsibility for resource utilization in the provision of patient care and are accountable for the results.

These activities are accomplished through the management process which involves the functins of planning, organizing, staffing, directing and controlling. Successful managrs will be those who understand and incorporate the management process into their daily activities. Decision-making skills are integrated in each of these functions, therefore this workshop begins with a presentation of decisin-making concepts.

Decision-Making

Objectives

The participants will be able to:

1. Differentiate between decision types.
2. Illustrate the steps in the decision-making.
3. Categorize the condition in which a decision needs to be made.
4. Develop a decision tree.
5. Apply Vroom and Yetton's decision-making tools.

Teaching helps

1. Suggested questions for student involvement
   How many of you made decisions at work last week? Did you have any difficulties with them? Why? Why not?
2. Lecture with transparencies
3. Exercise
4. Recommended readings - Decision-making: Corcoran, 1986; Daniel & Terrell, 1978; Marquis & Huston, chap. 2, 1987; Rakich et al., chap. 7, 1987. Planning - Archer, 1974; Fagan, 1987; Marquis & Huston, chap. 4&5, 1987; Nash & Opperwall, 1988.

Content

A. Definition and introduction
B. Discuss decision types
   1. End
   2. Means
   3. Administrative
   4. Operational
   5. Programmable
   6. Nonprogrammable
C. Decision quality
D. Decision process
   1. Conditions
   2. Steps
E. Decision helps
   1. Pay-off tables
   2. Decision grid
   3. Decision tree
   4. Vroom and Yetton's tools
F. Exercise
G. References

Decision-making

Definition

Decision-making is a deliberate cognitive process and an integral component of all management functions. It is the selection of a course of action from alternatives.

Types of decisions

1. End - decisions which determine outcomes or results.
2. Means - decisions which determine the strategies or activities utilized to obtain results.
3. Administrative - decisions determining structure, resources and policies.
4. Operational - decisions determining day to day activities or addressing day to day problems on a specific patient care unit.
5. Programmable - decisions that are repetitive and routine in nature. They can usually be automated in the form of policy and procedure manuals.
6. Nonprogrammable - decisions that are novel and unstructured. The situation occurs once or rarely such as the decision to change patient care organization from team to primary care nursing (Rakich, Longest & Darr, 1985, pp. 243-244).

Decision quality

Quality decision-making involves seeking and implementing the best possible solution to obtain desired results in an efficient and cost effective manner. Good decision-making incorporates the highest standards for action. Decisions should be as technically correct as possible with minimal negative effects produced. Research must be undertaken and outcomes anticipated before decisions are determined and finalized.

Managers use resources and are accountable for decisions regarding allocation and control of those resources. Successful decision-making requires the nurse manager be willing to decide and to have abilities and skills in decision-making. Courage, sensitivity to negative and positive aspects of alternatives, energy and creativeness also enhance decision-making.

Decision-making process

Managers make decisions under three conditions (Gilles, 1982, pp. 332-333). The first condition is decision-making under certainty. There is complete knowledge of the situation which is stable and without ambiguity. The decision-maker is able to elaborate on all alternatives, knows all resources required to carry out each alternative and can project a unique outcome for each alternative.

Decision-making under risk prevails when the determined alternatives have more than one outcome to which the decision-maker attaches a probability of obtaining the desired outcome. Attaching probabilities to alternatives helps the decision-maker select the solution with the highest chance of success.

The third condition is decision-making under uncertainty. In this situation no probability can be assigned in the prediction of outcomes being those desired. The more turbulent the situation (changing and uncertain) the greater the need for the nurse manager to use intuition, experience, judgement and qualitative activities for decision-making. The reverse is also true. The more placid the situation and simple the problem (stable and certain) the more scientific and quantitative activities can be used in decision-making.

There are six steps in the decision process (Rakich et al., 1985, pp. 246-250).

1. Know the institution's goals and priorities to facilitate departmental decisions being congruent with the organization.

2. Analyze the problem to determine what the situation is and what is needed to fix it. Separate the symptoms from the problem. If nurse A arrives at 0710 for the 0700 shift three times in one week is the problem lateness or is lateness a symptom of the problem? Gather data to determine the problem's history, cause, factors that can be changed and the desired outcomes.

3. Identify assumptions. All decision-makers bring assumptions to a decision situation which can affect the quality and selection of alternatives. Assumptions will fall into one of three categories.

a. Structural - These assumptions relate to the situation's content: Is it within or outside of the nurse manager's responsibility area? Are other departments or patient care units contributing to the problem? What are the resources available? Are there

uncontrollable factors present such as job design, process flow or technology? Are internal or external controls present such as legalities, regulations, standards, philosophies, cultural or political restraints?

b. Personal - These assumptions are unique to each nurse manager. They reflect biases and willingness for risk-taking as alternatives are proposed and decided upon. Personal assumptions evolve from one's experiences, knowledge, judgment, perceptions, personality, values and philosophy. Nurse managers must analyze self, acknowledging and dealing with biases and abilities to achieve impartial decisions.

c. Problem - These assumptions relate to the perceived importance of the problem and the urgency for a solution. Is the problem seen as important by the nurse manager and or the staff? Should the decision be made by the nurse manager or the staff? Does the decision need to be made soon?

Knowledge of assumptions is important as they can restrict the creativity, numbers and types of alternatives generated or selected.

4. Identify alternative solutions and project consequences of implementation. Analyze each alternative in terms of desired results, political acceptance, legalities, time-frame, feasibility of implementation, resources required plus costs versus benefits.

5. Make a decision selecting the best alternative and implement it.

6. Evaluate results and decide to continue the plan of action, refine or revise the plan or to terminate the plan and begin again.

Decision helps

A decision grid (Marquis & Huston, 1987, pp. 21-22) allows for visualization of alternatives comparing them against the same criteria. Any criteria may be utilized as long as they remain consistent for each alternative. An example of use would be comparing four vendor's cardiac monitors prior to the purchase decision.

Pay-off tables (Marquis & Huston, 1987, 21-22) look at cost-profit-volume relationships and help greatly with decisions where quantitative information is available. Historical data is required such as previous hospital census, number of births or number of

surgical procedures performed to determine probabilities. An example of use would be determining how many participants it would take to make a continuing education program offering break even or how many birthing room deliveries would it take to break even cost-wise for this new program's development and implementation.

Decision trees may be used to plot a decision for a specific problem over time where various decision outcomes can be visualized. There needs to be at least two alternatives under consideration. An example is the decision to fly or drive 900 miles to a nursing management conference in San Diego. Both alternatives are compared as to time and money required, if there is an accident, a delay or the trip is straight through. (see transparency)

Vroom and Yetton developed three decision tools to aid in the determination of using a group or an individual for decision-making (adapted from Vroom & Yetton, 1973 plus Marquis & Huston, 1987, pp. 24-26). The first tool describes five decision styles that can be used by nurse managers.

1. A1 (autocratic) - The decision is made by the manager unilaterally with the information available. An example is the charge nurse making out the day's assignment.

2. AII (autocratic) - Recognizing vital information is lacking the manager seeks input from the staff, then unilaterally makes a decision. The staff may/may not be told why the information is sought. An example is the head nurse is concerned about a staff nurse's attitude towards AIDS patients. Input is sought from staff and patients without telling them the concerns.

3. CI (consultative) - The head nurse shares the situation individually with relevant staff, obtaining input and suggestion then makes a decision. An example is the head nurse must decide what to do about complaints from medical residents regarding the new evening charge nurse. The situation is shared and input sought from the evening supervisor and charge nurse, the charge nurse's preceptor plus the medical residents. The head nurse's decision may/may not reflect the inputs received.

4. CII (consultative) - The manager shares the situation with the staff as a group, seeks their input, then makes a decision that may/may not reflect the group's input. An example is the surgery charge nurse

wants to cut down on over time hours. The situation is presented to the staff and suggestions obtained (10/12 hour shifts, 9-5/10-6 staggered shifts, hire additional staff), but the final decision may/may not reflect the staff's input.

5. GII (group) - The nurse manager shares the situation with the staff as a group acting only as the discussion leader. The group explores the situation, generates alternatives and makes a decision by consensus. The manager accepts any group decision and assists with implementation. An example is the surgery charge nurse is told the surgery back-log, due to a two week closure, must be made up over the next two months. The surgeons, anesthesia and surgery staff meet to discuss the situation. The current surgery schedule is Monday-Friday 0730-1530. The group decides to extend the Monday-Friday schedule until 1930 for one month rather than work every Saturday for one month or work until 1600 for two months.

The nurse manager must recognize that unilateral (AI) decisions are the least time consuming and group (GII) decisions are the most time consuming. The urgency of the situation thus plays an important role in determining which decision style is used.

The second tool Vroom and Yetton created is a list of seven variables to assist in determining which of the five styles is appropriate.

1. The importance of the decision quality.
2. The amount of information and skill the manager possesses.
3. The extent of the situation's structure.
4. The importance of the staff's commitment to the decision for its implementation.
5. The possibility of staff conflict over the decision.
6. The likelihood staff would accept a unilateral autocratic decision.
7. The staff's commitment/motivation to attain the organization's goals.

Vroom and Yetton's third decision tool consists of five rules which focus on time, decision quality or patient care goals.

1. AI is eliminated when the manager lacks decision skills and decision quality is important.
2. GII is eliminated if quality is important, but staff lack commitment to goals.
3. AI, AII and CI are eliminated with an unstructured problem, when the manager lacks decision

skills and quality is important, in addition to when staff's decision acceptance is critical, an autocratic decision would not be accepted or conflict is likely to occur.

4. AI and AII are eliminated if staff's decision acceptance is important and an autocratic decision may not be accepted.

5. AI, AII, CI and CII are eliminated if the decision quality is unimportant, but staff acceptance is necessary for success.

Suggested Transparencies

Decision-making is

- A deliberate process
- Selecting a course of action from alternatives
- A component of all management functions

Decision types

- Ends
- Means
- Administrative
- Operational
- Programmable
- Nonprogrammable

(Rakich et al., 1985)

Decision quality

Seeking and implementing the best possible solution

in an efficient and cost effective manner

Decision Conditions

Certainty Risk Uncertainty

(Gilles, 1987)

Decision Steps

- Knowledge of goals and priorities
- Problem analysis
- Identify assumptions
- Identify alternatives
- Decide and implement
- Evaluate

(Rakich et al., 1985)

Pay-off Table

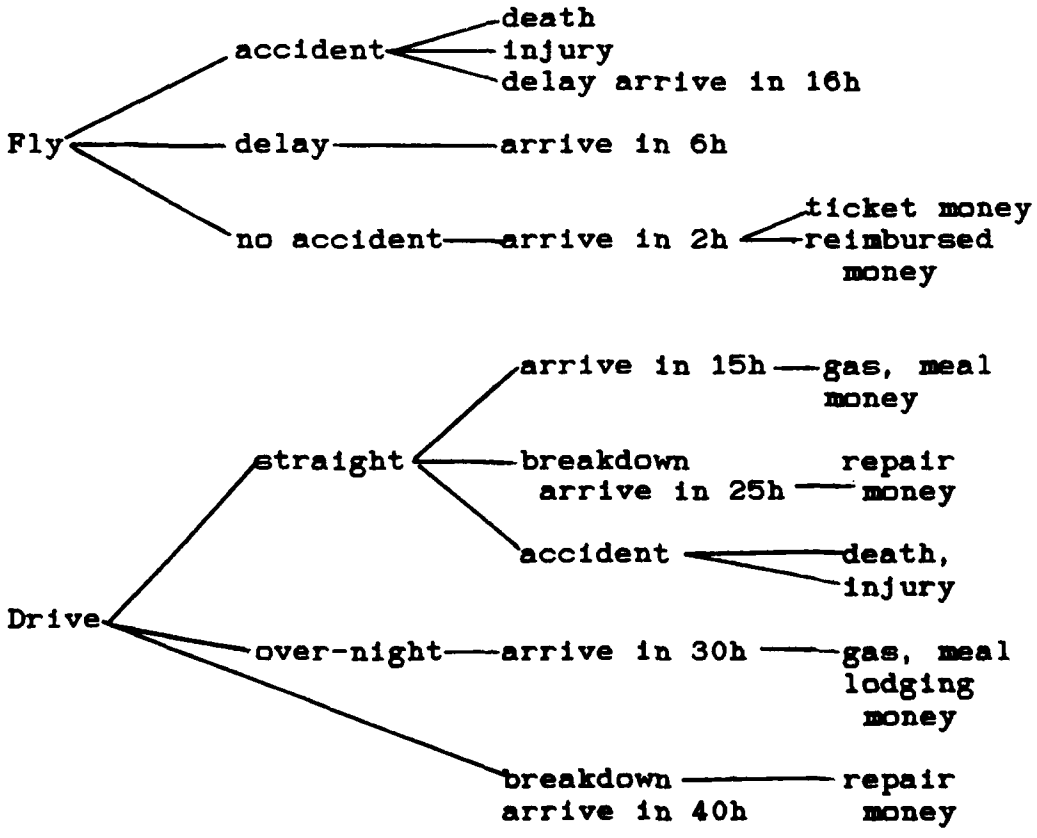
Breakeven Point

Decision Grid

Alternative	Cost/Revenue	Politics	Time	Decision
1.				
2.				
3.				
4.				

(Marquis & Huston, 1987)

Decision Tree



(Cocoran, 1986)

Vroom and Yetton's Decision Tools

- Five decision styles
- Seven situation variables
- Five decision rules

(Vroom & Yetton, 1973 & Marquis & Huston, 1987)

Exercises

In groups of discuss one of the following situations. Use decision steps and decision helps to arrive at the best possible decision. There are no wrong answers.

1. You are the charge nurse in a well-staffed operating room (Air Force). The chief nurse tell you a staff nurse will have to be loaned to the post-partum unit for two months starting in three weeks. You may send one nurse for the whole time or send two nurses for one month each. No one volunteers to go. How do you decide who goes and the length of stay.

2. You are the critical care head nurse. This year's week-long critical care convention is being held in the local area in three months. Today six staff members put requests on your desk to attend the convention. Only two nurses are allowed to be scheduled of the unit at the same time. You note another nurse placed a request for vacation time during the same period a month ago. How do you decide who attends the conference?

3. You are the head nurse of orthopedics, which is considered the model unit for quality patient care and staff morale. National nurses week is next week and the chief nurse has asked you to select a person from your unit for an on camera interview. How do you make this decision?

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Planning

Objectives

The participant will be able to:

A. Identify eight types of plans
B. Discuss the importance of philosophy and goals to planning
C. Construct a PERT planning network

Teaching helps

A. Suggestions for learner involvement
    1. Review of decision-making session, successess or failures with theory implementation
    2. Questions for discussion: What do you do when you plan? Can anyone tell me what a PERT network is?
B. Lecture with transparencies
C. Exercise
D. Recommended readings for organizing session: Blechert, et al., 1987, Farley & Stoner, 1989, Jay, 1981, Tropman, Johnson & Tropman, 1979, Wlody, 1981

Content

A. Definition and introduction
B. Eight types of plans
    1. Mission
    2. Philosophy
    3. Objectives and goals
    4. Strategic plans
    5. Policies
    6. Procedures
    7. Rules
    8. Budgets
C. Foundations for planning
    1. Philosophy, goals, objectives
    2. Policies, procedures
    3. Barriers to planning
D. Program planning
    1. Strategic planning
    2. PERT
E. Exercise

Planning

Definition and introduction

Planning precedes all other management functions. It is a systematic formal process enabling the manager to deal with the present and anticipate the future. Planning involves conceiving ideas, speculating, reflecting, deliberating and forecasting events. It is a conscious determination of a course of action, facilitating prioritization and quality decision-making assuring the probable outcome will be a desirable one. Planning is essential in today's competitive environment where resources are scarce and cost effective management the key to succeeding. Planning allows a head nurse to be proactive instead of reactive.

Types of plans

There are eight types of plans utilized by nurse-managers in health care institutions (Marquis & Huston, 1987, pp. 43-44).

1. Mission - the reason an organization or patient care unit exists, a generalized view of direction and priorities.
2. Philosophy - values and beliefs that guide all action of the organization and its departments.
3. Goals and objectives - the ends towards which the organization is working.
4. Strategic plans - introduce planned change, obtain resources accomplish goals and objectives.
5. Policies - statements that guide decision-making.
6. Procedures - a sequence of steps of required action.
7. Rules - define specific action or inaction allowing no discretion.
8. Budgets - plans expressed in numerical terms.

Foundations for planning

The mission, philosophy and goals are the foundations of planning which gives direction to employees for productivity (Marquis & Huston, 1987, p. 45). _Philosophy determines priorities in planning goals and in resource distribution. One's philosophy or value system impacts on decision-making, conflict resolution, leadership style and perceptions of people or events. Head nurses must know the institution's mission, philosophies and objectives prior to planning

for their area of responsibility so the two are in congruence facilitating success for the nurse manager.

Philosophies need to be translated into goals and objectives if they are to result in action. Goals are defined as the aim of a philosophy; its desired outcomes. Objectives are more specific, describing how goals are to be achieved. There are often multiple objectives for a single goal. Goals and objectives should be explicit, measurable, observable, realistic and obtainable. In addition they must be communicated if planning is to succeed.

Policies are comprehensive statements derived form the philosophy, goals and objectives. They guide the course and scope of activities, define broad limits and desired outcomes of commonly recurring situations leaving some area of discretion.

Procedures are the steps or processes used to implement a policy. They establish acceptable ways of doing a specific task and provide a rationale for each activity. Good plans, policies and procedures save time and money while increasing productivity.

Effective planning requires a goal to keep the planner focused. Plans are guides and therefore should be flexible allowing for unexpected events. All individuals and departments affected by the plans should be invited to contribute to the planning process. Plans should be simple, specific, obtainable and allow for evaluation.

A head nurse must be aware of and seek to overcome barriers to effective planning. These factors include:

- a lack of knowledge and planning skills
- a lack of organizational understanding; its culture, mission; philosophy and objectives
- a tradition of health care being delivered reactively in response to a problem, with management functioning in a reactive mode not a proactive mode
- a lack in understanding the external environment; the competition, the public, regulatory and legislative agencies
- inadequate organizational and administrative support of planning and implementation activities
- too much or too little detail in plans
- plans that are used to control rather than to inspire or to lead (Marquis & Huston, 1987, pp. 60-61)

Program Planning

Planning is a management function that involves the head nurse in shaping the future. Where do ideas come

from? They derive from an assessment of the external environment including the literature; professional (nursing), technological and demographic (birth-rate,aging,mobility, economy) trends; competitor's activities; regulatory, legislative and licensing activities; plus the public's concerns, desires and demands.

An internal environmental assessment also contributes program ideas. This includes the philosophy, goals and objectives of the organization, of nursing services and of one's area of responsibility. Ideas also develop from surveys of patients and staff; their ideas, concerns and complaints. In addition suggestion programs with incentives for utilized ideas and review of quality assurance program minutes provide input into program development.

Ideas become realities with strategic planning. There are five steps that can be used by head nurses in strategic planning.

1. Visionary thinking - a comprehensive future perspective, a dream for desired practice (case management, interdisciplinary teams, all RN staffs, bedside computers).
2. Identify any underlying contradictions to your vision (nursing shortage, limited financial resources, inflexible policies).
3. Develop strategic proposals to overcome contradictions (recruitment strategies-time owed for education the institution subsidizes, fund raising ideas, write and present a more flexible policy).
4. Develop specific plans to accomplish strategies; attain approval for implementation.
5. Establish an action implementation calendar and criteria for evaluating progress (Nash & Opperwall, 1988, pp. 12-13).

Once the contraindications for a new or revised program are removed the implementation process can be undertaken. This procedure necessitates a change taking place. The head nurse's knowledge and use of change theory will facilitate the program's successful implementation. Change theory will be discussed under the directing function of management.

<u>Program evaluation review technique - PERT</u>

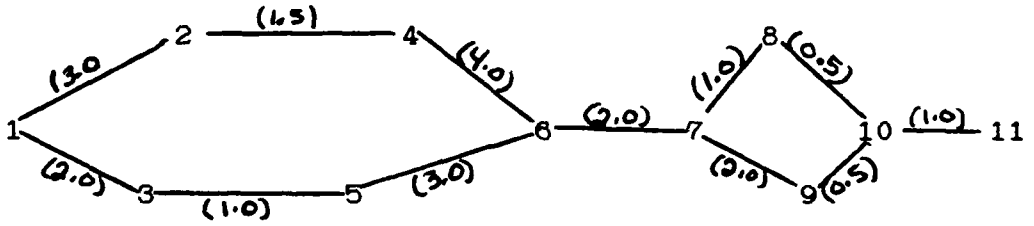
PERT is a technique that head nurses can use to identify sequencing of activities required for a specific project's implementation. It is a visual

planning and controlling device. It lets the planner look ahead, predicting problems and identifying solutions. PERT fixes responsibilities and measures progress against prescheduled activities. It is appropriate for programs that are conducive to time estimates and that have a definite starting and ending points. There are six steps in developing a PERT tool.

1. Define the outcome/goal precisely.
2. Determine all significant events. An event is a specific definable objective that leads to the goal.
3. Prioritize or sequence in the order they must be accomplished.
4. Determine essential activities or actions required for progression from event to event.
5. Determine the time-frame between events.
6. Prepare a PERT network or flow chart and post it where those involved in the project have access. It then becomes a monitoring/control device for evaluation of progress.

Reviewing an example (Archer, 1974 pp. 30-31) will make this technique clearer.

PERT Network



1 = Program decision made
2-10 = Events or objective to goal
--- = activities to achieve events
( ) = expected time-frame between events for example from 1 to 2 will take 3.0 weeks; from 1 to 3 will take 2.0 weeks.

The expected time (the) for each event to be completed is based on a formula using optimistic time (o), most likely time (m) and pessimistic time (p) plus two constants 6 and 4. The times are a best guess based on the head nurse's experience, knowledge and intuition. The formula is:

$$\frac{o+4(m)+p}{6} = te$$

if o = 1 p = 5
m = 3 te = 3

To determine the total expected time frame from program decision until program implementation add together the expected times for the longest path. In this example path 1, 2, 4, 6, 7, 9, 10, 11; that is 3.0+1.5+4.0+2.0+2.0+0.5+1.0 = 14 weeks.

Events are graphed in sequence. Some may be done currently; one path is 1, 2, 4, 6 at the same time path 1, 3, 5, 6; both must be completed before 7 can be done.

A PERT worksheet explains the PERT network and assigns calendar dates for work completion and assigns responsibilities.

Objective:

Plan/event	Activities	Target date	Assigned to	Remarks
1.				
2.				

Exercise

In groups of six to eight develop a PERT network for one of the following situations.

1. You've been appointed to a task force that's responsible for planning the annual hospital Christmas party (food, drinks, entertainment) to be held in four months.

2. You are the head nurse of a CCU in a medical center. You have an excellent reputation for your knowledge and skills. You've been asked by a smaller hospital to give a two-hour presentation regarding heart transplant patients. Specific CCU knowledge is not required for this exercise.

3. You are the charge nurse on the new pediatric unit. You and the surgery charge nurse have decided to develop have printed a preoperative teaching booklet for children and their parents.

Suggested transpariencies

Types of Plans

* Mission
* Philosophy
* Goals and objectives
* Strategic plans
* Policies
* Procedures
* Rules
* Budgets

(Marquis & Huston, 1987)

Foundations for Planning

Mission

Philosophy

Goals

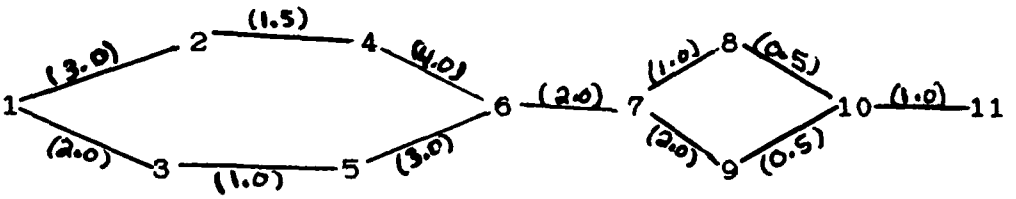
Strategic Planning Steps

Visionary thinking

Identify contraindications

Develop strategies

Establish calendar and criteria



1 = Decision made
2-10 = Events
( ) = Expected time for completing an event

o = optmistic time
m = most likely time
p = pessimestic time

$$\frac{o + 4(m) + p}{6} = te$$

te = time expected

(adapted from Archer, 1974)

PERT Workshop

Goal:

Event	Activities	Target date	Assigned to	Remarks

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Organizing

Objectives

The participants will be able to:

A. Identify barriers to effective communication
B. Illustrate uses of nonverbal communication
C. Identify stages of team development
D. Differentiate between task and maintenance roles
E. Identify reasons for committees
F. Illustrate four roles of committee chair-persons
G. Discuss committee member responsibilities
H. Plan a meeting agenda
I. Evaluate a meeting

Teaching materials

A. Suggestions for learner involvement
    1. Review of planning session, successes and failures with theory implementation
    2. Questions for discussion: Think of committies your involved with, are any time wasters? Are any run efficiently? What is the difference?
B. Lecture and transparencies
C. Exercise
D. Suggested readings for staffing session: Darling, 1984; Galbraith et al., 1981, Kapustiak et al., 1985, McClure et al., 1983.

Content

A. Definition and introduction
B. Communication
    1. Barriers to effective communication
    2. Nonverbal communication
C. Team building
D. Committee management

Organizing

Definition and introduction

Organizing is the key to bringing order out of chaos; the framework management uses to interrelate resources in the provision of quality patient care. Organization enables the staff to accomplish plans with efficiency and effectiveness. In organizing the head nurse looks at the tasks to be done, the relationships between tasks, the priorities for task completion and establishes line for communication and command. Good organization develops order, promotes cooperation, assigns tasks, defines processes and provides resources facilitating productivity.

Communication

It is essential for a head nurse to possess good communication skills. Research shows up to 80% of a manager's time is spent communicating ideas, plans, instructions or in the reception of feedback (Marquis & Huston, 1987, p. 241). There are three forms of communication: verbal, nonverbal and written. It is a two-way process involving a sender, a message, a receiver and feedback.

Communication is an art, a skill, an on-going process designed to provide information or change attitudes, behaviors or beliefs. Its function is to clarify, motivate and delegate. Effective communication occurs when both the sender and the receiver perceive the same message. Feedback is elicited to ensure both parties have the same understanding of the situation.

Perception of communication is highly individual based on one's values, needs, expectations, feelings, experiences and education. Perception is also due to the manner of the sender's speaking. Effective communication is descriptive rather than evaluative and uses "I" messages.

Poor communication can result in decreased morale, varied perceptions and decreased productivity. Barriers to good communication include (Marriner-Tomy, 1986):

-faulty reasoning
-poorly expressed messages
-lack of clarity, coherence and precision
-no congruence between nonverbal and verbal communication
- talking too fast or too slow

-slurring words
-rambling
-not listening
-not obtaining feedback

To improve communication plan before speaking. Identify the purpose of the message. Consider the knowledge, skills, attitudes and goals of the recipient. Use clear simple sentences, avoiding jargon. Recognize timing is important. Do you want to denote urgency or importance? A quick verbal response to a formal written message may indicate you felt the message wasn't important enough to spend time and effort on the reply.

Listening is a vital component of the communication process and includes: facing the speaker, looking interested, using eye contact, stopping talking, not finishing sentences, avoiding judgements, asking pertinent questions and providing feedback on the message heard. Nonverbal communication also transmits messages. A head nurse can learn a lot about those one is communicating with by assessing their nonverbal communication. Remember they are also learning about you.

The space between the sender and the receiver influences what is perceived; too little space and anxiety is felt while too much space may be seen as a lack of interest. Where communication occurs sends a message. Do you always have the staff come to your office or do you get out into their environment? Do you give praise in public and care enough to give negative feedback in private?

Body language and appearance are powerful communicators. What is the image you desire to project? Does your dress and grooming reflect sloppiness, disorganization, sexuality or does it reflect a neat organized business oriented individual with pride in themself? An erect posture indicates confidence. Down cast eyes indicate anxiety and lying while eye contact is associated with confidence, sincerity and interest. Facial expressions often reflect emotions. Eyes fill with tears for sadness, frustration and joy. Tone, volume and vocal inflection can add emphasis to the message point. Gestures may be used in the same manner, but if overdone result in distractions.

Team building

Health care organizations are compromised of many teams such as the management information team, the executive management team and the nursing team. Today there is a trend towards interdisciplinary teams. The teams consist of members from various professional disciplines bringing together their skills and expertise for a common goal.

Team members must work together in order to accomplish their goals. Building a team is a process of bringing individuals together and integrating them into a single entity for the achievement of a common purpose.

A head nurse needs to recognize staff member's value systems are reflected in the way they function as member of the unit's patient care team. Raines (1988, 324-330) has identified six value systems that affect behavior.

- Kinsman: believe in bonding together for survival.

- Loners: believe survival of the individual is the highest priority. The world is seen as hostile and opportunities are sought to dominate it.

- Loyalists: believe in rules and regulations, law and order and like things crisp and formal. They are conservatives who value duty and honor, respect tradition and resist change.

- Achievers: believe in individualism. They're energy driven, confident and fast paced always striving for excellence. They like to make things happen enjoying the subsequent recognition and rewards.

- Involvers: believe in love, fairness and equality. They value cooperation and group membership. They're skeptical of authority. They emphasize people often to the point of neglecting the task. They'll speak up for what's believed in, search for job satisfaction demanding a voice in decision-making and options. They're often influenced by peer pressure.

- Choice seekers: believe in freedom and autonomy. They're usually experts with a technical background who value intellectual stimulation and privacy.

The integration of individuals into a team occurs over time and through several stages. Teams differ in the amount of time spent in each stage and may go back and forth between stages. Researchers vary on the names and number of stages, but all agree on the basic

content and sequencing of events. This discussion will encompass four stages of team development.

The first stage is orientation where individuals come together for a purpose. They are anxious, not knowing what is expected or who can be trusted. There is an artificial politeness with feelings and emotions held in check. Members try to identify why am I here? What will I get out/gain from this? Will I be valued or accepted? Can I perform what will be required of me? What is acceptable behavior?

The second stage is experimentation. The group decides to improve its performance, after answering the questions noted in stage one. Goals, tasks, roles and norms are identified. As roles are negotiated conflict may arise, however there is now a level of trust, beliefs and disagreements are expressed openly where they can be delt with. Active listening occurs facilitating member's understanding and respecting each other's skills, knowledge and abilities. Collaboration begins as goal achievement is planned.

Production is the third stage of team development. There is honest, assertive effective communication. The focus is on procedures and performance rather than individuals and personalities. The team becomes effective as it adopts a systematic problem solving approach to the issues at hand. Each member's skills and talents are used and cohesion is strong. There is a sense of pride in performance.

The final stage is dissolution. Assessment and evaluation is the focus to determine if the work done achieved the desired goals. The task has been completed. The team is dissolved, refocused onto a new task or may be revitalized with membership changes.

Researchers have identified two major roles (Schermerhorn, Hunt & Osborn, 1985) that group members can perform enabling teams to remain effective over time. The first role involves task related activities. Task achievement is the focus and the following roles are undertaken:

- Seeking information from group members
- Giving information to group members
- Initiating ideas or suggestions
- Clarifying relations between ideas
- Summarizing the group's decisions and discussions

Maintenance activities strengthen team interactions improving interpersonal relationships and communications using the following roles:

- Harmonizing: reconciling differences, offering compromises
- Encouraging: accepting other's ideas, praising
- Following: going along with the group's decision facilitating consensus
- Setting norms: role modeling accepted behavior
- Gate keeping: assisting all members in contributing

The responsibilities for these activities are shared by all group members. No one person is responsible for acquiring and "playing" any specific role for any period of time. Since these activities must occur in balance for effective team functioning the leader should have knowledge of teams and elicit these roles or take some of them on as the situation requires.

With an understanding of team development and roles the head nurse can facilitate team building when in either a member role or a leader role. The first step in team building is to identify the purpose for its existence. Is there a problem? Does a change need implementation?

Once the purpose is identified a group is gathered. The members specifically define the situation and identify goals by consensus. Unless all members are in agreement and committed to the goals team work will often be nonproductive. Goals must be defined prior to continuing with strategy development, implementation and evaluation processes.

Committee management

As head nurses you will be chairing or managing committees. If the average committee has 10 members with an average hourly wage of $14.00; a one hour meeting that is nonproductive just through away $140.00 plus wasted time and energy that could be used elsewhere. Think of the number of committee meetings you attend, the number of members, and the wages being paid. Is money being thrown away? Not if the meeting is well run and productive. Committees can be valuable sources for original ideas, creative thinking and quality decision-making or problem-solving. Effective efficient committee management like team building takes knowledge and skills.

The chair-person has several roles (Tropman Moringstar, 1985). He/she set the tone for the committee as serious and business oriented or as a social gathering wasting resources. In the leadership

role enthusiasm and support are provided, ideas are explored and blended with neutrality being maintained.

The administrative role involves seeing all planning and preparatory procedures are performed. The agenda is prepared and distributed and provisions made for taking minutes. The chair arrives to the meeting 10-15 minutes early to set up the room and greet members as they arrive. The administrative role also assists the group in setting norms and standards of behavior.

The chair is a spokesperson, representing the committee to the rest of the organization, reflecting committee view and not one's own. The chair may speak for absent members after securing their opinions and ideas.

The final role is that of meeting head. Authority is used to guide and direct the meeting seeing the agenda is followed, not for promoting oneself. Weaker members are protected and their contributions elicited.

The member's role (Tropman, Johnson & Tropman, 1979) is to enforce and live by committee rules, that is to arrive on time prepared and with a positive attitude. Members are responsible for their participation and allowing others to contribute on an equal basis. Outside of the committee they should always be alert to information that may help the committee reach its goals. They should help the chair keep the meeting moving, aid in dealing with disruptive members, follow through with delegated assignments and demonstrate loyalty to and discretion about committee discussions and decisions.

There are two other roles that need to be periodically undertaken; the task and maintenance roles discussed under team building.

A committee meeting is not a social gathering. An agenda focuses on the business at hand, providing structure for the meeting. It organizes producing efficiency and effectiveness. Agenda items should be short simple clear statements ending with an action verb (ie.for: information, discussion, decision, resolution). The person presenting the issue is also identified on the agenda.

The items which are apt to need creativity or produce conflict should come early in the agenda. The most important items should be in the middle third of the agenda when energy, interest and attendance are the highest. Listing "other business" on the agenda can be an invitation to wasting time. It may be better to

make an announcement calling for additional urgent items at the appropriate time.

The agenda and selected reports should be circulated a minimum of two to three days prior to the meeting. Reports should be brief and simple not longer than two pages. Longer reports should be summarized and the full report made available to members upon request.

Agendas open meetings and minutes document them. If an issue is important enough to meet about it is important enough to document. Minutes must be accurate reflecting tasks accomplished, tabled and assigned. Discussions and debates are summarized, key points noted, action taken recorded, but without naming disputants. The focus is on the issue not the person. The chair-person is responsible for seeing minutes are taken, functioning as recorder, appointing a recorder or seeking a volunteer for the task.

Effective meeting management requires knowledge and skills. First there must be a purpose and goals for committee activities. The chair needs to emphasize an understanding of member's other commitments, thus promptness is valued and time limits set with meetings starting and ending on time. The chair seeks to keep their own energy level high, demonstrate interest, alertness and enthusiasm in role modeling. Humor is invaluable as long as it is in good taste and appropriately timed. Keep members informed what is expected of them and where the committee is going. Use the knowledge of every group member, drawing out those who are silent without putting them on the spot. Eliminate domination by a member with phrases such as - That's a good point, but I'd like to hear from..; That is interesting, but how does it relate; I must not have been clear, I'd like to focus on ...

During discussions the focus should be on issues not people. The environment should reflect trust, acceptance and fairness. At the meeting's end the chair should summarize the work accomplished and thank members for attending.

The chair-person's final task is to evaluate the effectiveness and efficiency of the meeting. Some questions that can be used in the evaluation process include:

	Yes	No	Comments
1. Did the chair model desired behavior, arriving on time, prepared, positive attitude?			
2. Did the chair remain neutral?			

3. Did all members know the meeting's purpose?
4. Was an agenda distributed 2-3 days prior to the meeting?
5. Did the meeting begin and end on time?
6. Was the agenda followed?
7. Was the environment trusting and supportive?
8. Did all members contribute?
9. Was conflict resolved constructively?
10. Were meeting goals achieved? Action taken on agenda items?
11. Did members leave with a feeling of accomplishment?
12. Were the proceedings recorded accurately?
13. Was the date and time convenient for members?
14. Was the room adequate (light seating,etc)?

Nonverbal communication exercise

In groups of six to eight discuss the following situations. Prepare a brief summary for presentation.

1. You're the head nurse in the Neuro ICU. A new staff nurse has just completed orientation. She has good technical and interpersonal skills. Yesterday one of her patients died. During the code she functioned efficiently and confidently and stated afterwards she felt she'd done a good job. Today you've noticed her hands shaking as she does tasks. She rechecks every action 2 or 3 times and has refused to take a break or go to lunch. Her expression is tense, her posture rigid. Analyze the nonverbal behavior. What if anything would you do?

2. Kathy was selected as evening charge nurse six months ago and has done an excellent job. She was selected as outstanding nurse for the quarter due to professional appearance plus interpersonal and patient care skills. Last week she was 10 minutes late twice. Over the last two weeks she's often come to work looking tired and disheveled, with puffy red eyes. Kathy is suppose to precept 2 senior student nurses during a three week evening rotation to evenings. Discuss her nonverbal behavior and determine what if anything you would do.

3. As head nurse you are doing career counseling with a member of your staff. She graduated two years ago from an ADN program. She states she's really enjoys nursing and is interested in the evening charge nurse position. When you mention there is a charge nurse workshop next month she replies that is great and changes the subject. You bring up the prerequisites for management positions include a preference for nurse with BSNs and suggest she take a class toward that ends. She starts biting her nails and sighing and notes she needs to get back to her patients. How might this nonverbal behavior be interpreted?

Suggested Transparencies

Communication

Sender ----- Message ---- Receiver

Feedback

Up to 80% of a Manager's Time is

COMMUNICATING

(Marquis & Huston, 1987)

Barriers to Effective Communication

- Faulty reasoning
- Lack of precision, clarity, coherence
- Incongruence in verbal and nonverbal messages
- Talking to slowly or to fast
- Slurring words
- Rambling
- Not listening
- Not obtaining feedback

(Marriner-Tomy, 1986)

Nonverbal communication

- Space
- Environment
- Appearance
- Posture
- Facial expression
- Eye contact
- Voice
- Gestures

Stages of Team Development

1. Orientation
2. Experimentation
3. Production
4. Dissolution

Task Activities

1. Information seeking
2. Information giving
3. Initiating
4. Clarifying
5. Summarizing

(Schermerhorn, et al., 1985)

Maintenance Activities

1. Harmonizing
2. Encouraging
3. Following
4. Setting standards
5. Gate keeping

(Schermerhorn et al., 1985)

Chair-person Roles

- Leadership
- Administration
- Spokesperson
- Meeting head

A COMMITTEE IS NOT A SOCIAL GATHERING

AGENDA = STRUCTURE

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Staffing Function

Objectives

The participant will be able to:

A. Identify why nursing retention is a critical issue
B. Discuss what nurses expect of their practice
C. Use motivation theory as a retention strategy
D. Discuss the characteristics of a good mentor

Teaching helps

A. Suggestions for learner involvement
    1. Review of organizing session, successes and failures with theory implementation
    2. Questions for discussion: Have you ever changed job because you were dissatisfied? Have you thought about leaving nursing? Why? Has someone helped advance your career? What did they do?
B. Lecture with transparencies
C. Suggested reading for directing session: Courtade, 1978; Jenks & Kelly, 1985; Levenstein, 1979; Levenstein, 1981; Welch, 1979

Content

A. Definition and introduction
B. Retention issues
    1. Need for retention strategies
    2. Nurse's retention issues
    3. Motivation theory as a strategy
        a. Hertzberg's two factor theory
        b. Maslow's and McClelland's needs theories
        c. Adam's equity theory
        d. Vroom's expectancy theory
C. Staff development
    1. Orientation, inservices, continuing education
    2. Mentoring - developing tomorrow's leaders

Staffing

Definition and introduction

The focus of the staffing management function is the acquisition and retention of human resources. The health care industry is labor intensive, therefore effective staffing management is an essential head nurse role. The following factors impact on the staffing function:

- organizational philosophy, objectives and fiscal resources
- type and number of personnel available
- competitiveness of salaries and benefits
- attrition rate
- head nurse's ability to match personnel to job interests and requirements
- staff development resources available
- centralized or decentralized management pracitices
- head nurse's ability to create a motivating environment

This presentation will focus on retention issues in nursing and then staff development issues with an emphasis on mentoring.

Retention

Retention of good nurses is one of the most critical issues facing head nurses. Today many professions are actively recruiting women, offering significantly more financial and job related benefits than does nursing. Englehart noted there was a 50% decline in nursing education enrollments from 1974 through 1976 while the nurse patient ratio increased form 50 RNs per 100 patients to 85 RNs per 100 patients.

Retaining nurses results in significant economic savings for a hospital. The average recruiting and orientation costs for general duty nurses are $3000 to $5000 and $5000 to $10,000 for speciality nurses (ICU, OR). These costs represent an average of 60 - 90 days to recruit and hire; 3-6 months or orientation and monies paid for overtime and agency nurses to fill in staffing gaps.

A review of the literature pinpointed some specific issues leading to dissatisfaction in nursing. Hinshaw, Smeltzer and Atwood's (1987, pp. 8-16) research indicates nurses:

- Desire organizational satisfaction. This relates to the pay/reward system, management styles, professional status and collegial relationships.

- Desire professional satisfaction. This relates to perceptions of the quality of care delivered, having the time and resources to deliver good care. Nurses desire to give quality care.

- Have professional expectations. This equates with a desire for nurses as professionals to control their own practice.

Kerfoot (1988, pp. 41-43) found nurse want to be able to commit to their organization's mission, philosophy and goals. They also desire to be part of a positive supportive culture and to feel a sense of esprit-de-corps or team pride. The latter is reflected in the image of the organization, of their assigned patient care unit and of nursing itself.

The Magnet Hospital (McClure, Poulin, Sovi & Wandelt, 1983) study discovered similar issues concerned nurses.

- Nurses desire their head nurses to demonstrate a visible, accessible and participative management style.

- Leadership quality is important. Strength, knowledge, support open communication plus fair and equal treatment is looked for in managers.

- The organizational structure should facilitate positive relations between staff and management.

- Staffing needs to be adequate in both quality and quantity.

- Personnel programs and policies should allow for flexible scheduling, adequate salaries and benefits, staff development programs, social and recognition programs plus child care facilities.

- Professional practice is desired that encompasses quality assurance, autonomy, consultation, collaborative/interdisciplinary patient care approaches, primary nursing, research, and community involvement.

- Professional development should be available in the form of orientation, inservice and continuing educational activities. Career ladders, career counseling and formal educational opportunities are also sought.

Head nurses familiar with retention issues and motivation theory can combine the two in planning strategies to cope with the retention problem.

In the Hertzberg (Schermerhorn et al., 1985)

described a two factor theory that could be used in categorizing today's retention issues. The first category includes hygiene factors which are sources of job dissatisfaction. Eliminating them decreases dissatisfaction, but does not increase job satisfaction. These factors involve: security, status, relationships with supervisors, peers and subordinates, personal life, work conditions, supervision, policies and administration.

The second category Hertzberg call motivators. These factors are sources of job satisfaction and include: growth, advancement, responsibility, the work itself, recognition and achievement.

Maslow and McClelland proposed that people are motivated (to stay on the job) to work to fulfill needs. Maslow (Schermerhorn et al., 1985) identified five levels of needs that people seek to satisfy. Physiologic needs include food, water, clothing, shelter and the financial means to obtain them. Safety needs include security, absence from pain, working conditions and job stability. Love and belonging needs encompass affection, friends at work and being part of a team (esprit-de-corps). Esteem needs include achievement, recognition, respect, responsibility and status. The final level is self-actualization needs which include feeling self-forfilled, realizing one's potential and achievement.

McClelland's (Schermerhorn et al., 1985) research found people have needs in three areas. First people want to achieve, to continuously better themselves (staff development). He also found people have a need for affiliation. They desire close ties and friendly relations on the job. The third arena is a need for power. People desire to influence others and have control over situations.

Another motivation theory is described by Adams (1963, pp. 422-436) as an equity theory. He believes workers compare their inputs (work effort) and outcomes (rewards) to their co-workers. Inequities exist when one perceives the rewards received are unequal to a co-worker's when the input is perceived to be equal. The worker's motivation and job satisfaction may decrease, leading them to look elsewhere for employment.

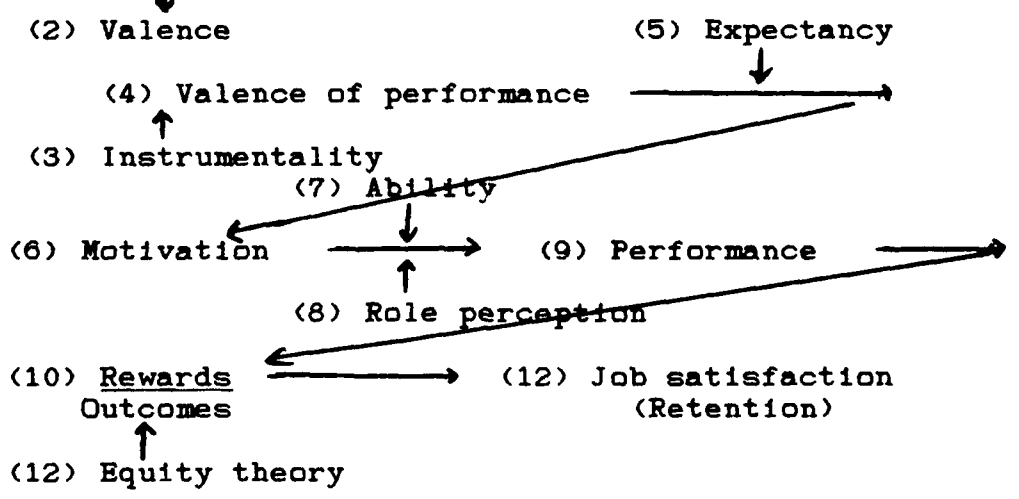
The final theory for discussion is Vroom's expectancy theory which has three components.

1. Valence: The value the worker places on the outcomes or rewards offered by management. If a reward has no value it will not be sought.

2. Instrumentality: The probability that a given work effort or performance will actually be rewarded.

3. Expectancy: The probability the worker's effort will lead to performance. If the worker tries will he/she succeed?

These theories can be combined and used by head nurses as strategies to promote job satisfaction and retention.



(1) Head nurses must identify their staff's needs as a group and as individuals.

(2) Needs can be translated into outcomes or rewards, increasing the likelihood the reward will be valued by the worker and a work effort will be made to obtain it.

(3) The rewards a head nurse states will be given must be followed up with action. This aids in establishing a trusting relationship, where what is said will be done. If there is no reward there will be less effort and more dissatisfaction in the future.

(4) Lets the staff know the performance is valued

(5) Staff members want to be able to do the job, to know their effort will result in performance. If they don't think they'll succeed they may try half-heartedly or not try at all. The head nurse needs to match the worker and the task, to provide guidance and support.

(6) The staff member who values the reward offered, knows effort will be rewarded and expects to succeed will be motivated to perform.

(7) Abilities affect performance quality. The head nurse needs to provide honest performance appraisals;

if abilities are lacking a plan for development is devised and implemented so future performance will be quality performance.
(8) Role perception impacts on performance. If job descriptions or head nurse-staff expectations are unclear or ambivalent the performance obtained may not be desired. This can lead to frustration and job dissatisfaction.
(9) Valence, instrumentality, expectancy, abilities, and clear role perceptions results in the desired performance.
(10) The desired performance is rewarded.
(11) For the staff member to be satisfied with the reward it must be seen as equitable to peer rewards. The head nurse should distribute rewards fairly and equally, taking into account specific rewards will not hold the same value for each worker.
(12) Nurses who's needs are fulfilled with desired performance rewards seen as equitable are likely to experience job satisfaction and tend to remain with their employer (retention).

Staff Development

As mentioned previously nurses desire opportunities for growth. Education is an on-going process and a nurse manager's responsibility. Staff development activities include orientation, inservices and continuing educational workshops. Staff development provides knowledge and skill for patient care and management activities. This facilitates quality patient care, improved productivity, decreased costs and increased job satisfaction. Attendance at continuing educational offerings is also seen as a reward for current performance as well as a help for future performance.

It is important staff members participate in need identification, planning, implementing and evaluating educational offerings so patient care needs can be met in a cost effective manner. In today's environment where fiscal and human resources are short monies should not be spent on educational presentations unless an improvement in quality patient care is the goal.

The head nurse can become directly involved in staff development when serving in a mentoring role. Mentoring can be a cost-effective method to develop tomorrow's nursing leaders. Atwood (1979) believes those nurses now in influential positions must take on the responsibility of grooming other promising nurses.

Mentoring is a fashionable term today, however its roots are in mythology where Mentor was a teacher, counselor and guide to Odysses's son. In nursing history Florence Nightengale's mentoring changed forever the British healthcare system by sending her protegees to improve nursing care, health care and nursing education. Head nurses can show their commitment to the future and touch tomorrow with mentoring activities.

Research has identified 14 mentoring activities (Kelly, 1987, p. 44).

1. Model - someone who is looked up to, valued admired, an expert one desires to emulate.
2. Envisioner - creates an image, goal or vision of the profession that is meaningful to the mentee.
3. Energizer - makes nursing exciting, is enthusiastic and dynamic.
4. Investor - invests time and self, believes in the protegee and communicates that belief, saying we not I.
5. Supporter - listens, provides emotional support, encouragement and reassurance. Instills confidence, facilitates experimentation and risk-taking, allows mistakes.
6. Standard-setter/prodder - sets the standard of a professional of excellence, helps mentee set his/her standard then gently pushes or prods the mentee toward achievement.
7. Teacher-coach - challenges with discussions, evaluates, teaches priorities, interpersonal skills, guides problem solving. Teaches by self disclosure.
8. Feedback-giver - examines situations, provides both positive and negative feedback based on direct observations using I messages.
9. Eye-opener - broadens perspectives, exposes to new ideas, concepts and possibilities.
10. Door-opener - willingly provides opportunities and paves the way whether to attend classes, sit in on meetings, serve on committees or participate in projects.
11. Idea-bouncer - discusses issues, problems and goals with the mentee, acts as a sounding board, offers opinions. Never divulges a confidence.
12. Problem solver - assists in examining problems and finding solutions.
13. Career counselor- discusses career issues, interests, choices, long range plans and how to achieve them.

14. Challenger - stimulates critical thinking and deep issue exploration.

Peters and Austin (1986, pp. 415-416) discuss what a mentor is not. Mentors do not encourage their protegee's dependence or use the role for controlling rather than giving. Mentoring is not parenting, thus the mentor should not become involved in the mentee's personal decisions. Mentors should not be threatened by a protegee's knowledge or skills. Neither should they choose only those individuals to guide who are just like themselves.

Toxic mentor relationships (Galbraith, Brueggemeyer & Manweiller, 1988) can take four forms. The first is avoider where the mentor can never be found when they are needed. The dumper hands out tasks offering no direction or guidance placing the mentee in a sink or swim situation. The blocker denies the mentee access to information, while the destroyer undermines and critizes the mentee.

For the relationship to be productive both parties must be sure they want to undertake the time and effort required for a mentee - mentor relationship. The potential mentor shouldn't accept mentee out of flattery, but should truly want to help. Don't try to mentor too many individuals at the same time. Do realize the relationship won't last forever.

Potential mentees have responsibilities. They must soul search to identify dreams, goals and objectives. To be a good mentee one must be able to accept help, to listen, be reliable, diplomatic and show appreciation for help received. They need to ask for guidance, be loyal and conduct themselves in a manner to make the mentor proud.

The relationship should develop naturally, not coercively. This does not preclude a potential mentor or mentee from seeking a relationship with the other.

There are four stages (Bunges & Cantor, 1988 & Galbraith et al., 1988) to a mentor-mentee relationship. The first stage is inititation. Mutual role definition and bonding occurs. Measurable goals and objectives are established. There is work on common projects. A log kept by the mentee assists with discussion of learning and growth experiences. During the training or cultivation stage the protegee progresses to independent functioning. Guidance is sought with the mentor providing challenges without frustrations. Autonomy is encouraged and career planning occurs for the next 2 to 10 years.

Performance is analyzed and and goals kept, revised or eliminated. Termination is inevitable, but the timing is critical. If it is premature the protegee may experience anxiety and insecurity; if the separation is postmature the protegee may become to dependent on the mentor. The fourth stage is redefinition characterized by a lasting friendship where the protegee moves into a peer relationship with the mentor. Mentees now become mentors, thus there is continuing development of tomorrow's nursing leaders.

Suggested Transparencies

Staffing

The acquisition and retention of human resources

Hinshaw et. al.:

Organizational Satisfaction

Professional Satisfaction

Professional Expectations

(Hinshaw et al., 1987)

Kerfoot:

Commitment

Support

Team Pride

(Kerfoot, 1988)

Magnet Hospital Study:

Participative management

Quality leadership

Positive relations

Adequate staffing

Personnel policies & programs

Professional practice

Professional development

(McClure et al., 1983)

Hygiene factors -------- Dissatisfaction

Security

Status

Subordinate, peer, supervisor relationships

Personal Life

Work conditions

Supervision

Policies and administration

(Schermerhorn et al., 1985)

Motivation factors -------- Satisfaction

Growth

Advancement

Responsibility

Work itself

Recognition

Achievement

(Schermerhorn et al., 1985)

Maslow:

Needs

- Physiologic
- Safety
- Love and Belonging
- Esteem
- Self-actualization

(Marquis & Huston, 1987)

McClelland:

Needs

- Achievement
- Affiliation
- Power

(Schermerhorn et al., 1985)

Adams:

Equity Theory

Workers compare

Their inputs - outcomes to other's input - outcomes

(Adams, 1963)

Vroom:

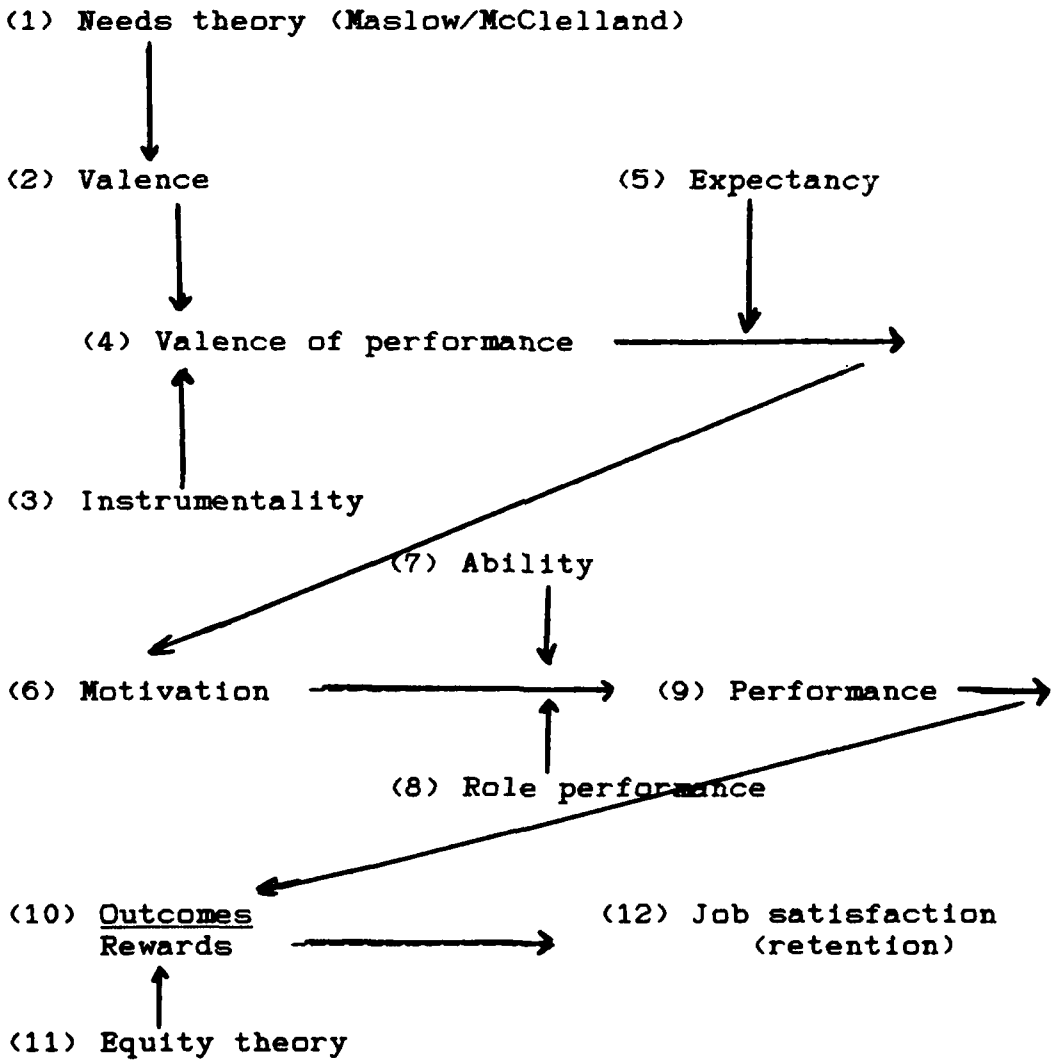
Expectancy Theory

- Valence - value give to outcomes/rewards

- Instrumentality - probability the work effort will be rewarded

- Expectancy - probability work effort will lead to performance

(Vroom; 1964)


(1) Needs theory (Maslow/McClelland)
(2) Valence
(5) Expectancy
(4) Valence of performance
(3) Instrumentality
(7) Ability
(6) Motivation
(9) Performance
(8) Role performance
(10) Outcomes
Rewards
(12) Job satisfaction
(retention)
(11) Equity theory

Staff development = Orientation

Inservice

Continuing education

Mentoring = Developing tomorrow's leaders

(Kelly, 1987)

Mentor Characteristics

Model

Envisioner

Energizer

Investor

Supporter

Standard setter/prodder

Teacher-coach

Feedback giver

Eye-opener

Door opener

Idea bouncer

Problem solver

Career counselor

Challenger

(Darling, 1984)

Toxic Mentors

* Avoider
* Dumper
* Blocker
* Destroyer

(Galbraith et al., 1988)

Stages of Mentorship

1. Initiation
2. Training-Cultivation
3. Termination
4. Redefinition

(Bunges & Cantor, 1988 & Galbraith et al., 1988)

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Directing

Objectives

The participants will be able to:

A. Discuss sources of power
B. Identify uses of power
C. Illustrate power builders
D. Identify Lewin's three phases of change
E. Construct a force field analysis
F. Identify excuses for not delegating
G. Differentiate between dos and don'ts of delegating
H. Identify psychological tactics of negotiation
I. Apply guides for effective negotiations

Teaching helps

A. Suggestions for learner involvement
    1. Review staffing session, successes and failures with theory implementation
    2. Discussion questions: Do you have power? Where does it come from? How do you use it? Do you bring work home often? Do you delegate effectively?
B. Lecture with transparencies
C. Exercise
D. Recommended readings for controlling session: Baird, 1988; Hines, 1988; Kersey, 1988; Spitzer, 1988

Content

A. Definition and introduction
B. Power
    1. Sources
    2. Uses
    3. Builders
C. Change theory
    1. Lewin's three phases
    2. Change strategies
    3. Force field analysis
D. Delegation
    1. Excuses for not delegating
    2. Delegation dos and don'ts
E. Negotiation
    1. Preparations
    2. Psychological tactics
    3. Guides to effectiveness

Directing

Definition and introduction

A head nurse's role includes directing the work efforts on patient care units. The focus of directing activities is initiation. The head nurse uses power to introduce change, to delegate and to negotiate in directing the staff's activities towards the accomplishment of quality patient care.

Power

Power the is capacity to influence and get work done by others. The demand for a head nurse's attention by staff, patients, physicians, visitors, administrators and phone calls suggests a powerful person. Power is necessary to reach goals. Power is control. Power is nonexistent unless one has the self-confidence and courage to use it.

Power implies a relationship. If no one is influenced there is no power, irregardless of the job title one possesses. Power is derived from six sources.

1. Reward power is the ability to provide rewards. Desire for the reward produces the desired behavior.
2. Coercive power is an ability to provide punishment. Fear produces the desired behavior.
3. Legitimate power is based in one's official job position. It is constant for all individuals in that position.
4. Referent power is based on admiration. The followers desire to be like the leader, behave like the leader.
5. Expert power is due to one's knowledge, skills and the information possessed.
6. Personal power stems from educational experience, drive, reliability and credibility. A happy positive temperament, attractiveness, friendships, associations, religion, race and politics also impact on one's power base.

Power can be used in several ways (Levenstein, 1981, p. 24-25). It is neither good nor bad in itself, but is defined by the user. Exploitive power is destructible. People are used to forward the power user's own ambitions to the determent of every one but the user. Staff may be demeaned to bolster the manager's ego. In contrast nutrient power is exercised in behalf of another.

Manipulators of power influence others without their consent, but without force. Deception is often used. Integrative power occurs when two or more individuals together use their influential powers to enhance the interests of all parties. Competitive power occurs when there are choices to be made from a pool desiring the same

objective. The head nurse is involved in competitive power when he or she must choose an assistant head nurse from four applicants.

Power is obtained only through active means. Skills in entrepreneurial activities, politics, leadership, decision-making, communication and conflict resolution provide a good base for power achievement. Other aids to power building are (Courtade, 1978):

- recognizing the leadership skills, strength and power one has then being confident and willing to use them.
- recognize one's power deficiencies and take corrective steps such as continuing education activities, being active in professional organizations and obtaining a master's degree.
- build a support system, network and obtain a mentor.
- identify and use nonverbal communication to project an image of power for example dress, erect posture and eye contact.
- act impeccably, never reveal all of yourself.
- learn time management.
- accept mistakes made, learning from them and continue onward.
- know who has the power in your institution.

Individuals can become obsessed with obtaining power. They are often more concerned with an activities impact than with its quality. Pains are taken to see official actions are highly visible. They often convert discussions into debates. Power hungry individuals avoid activities that contribute nothing to personal, positional or social power. Their schedules are packed with interviews, conferences, meetings and social affairs. A busy schedule implies power and importance, too busy to see some staff or peers, forcing others to accommodate to the busy schedule hoping to imply the busiest schedule belongs to the most powerful person. Power oriented people prefer making calls over returning them.

Head nurses must recognize the legitimacy of using power for goal attainment. With power a head nurse can move mountains, change situations or at the very least facilitate activities that will result in quality patient care.

Change

It is essential for head nurses to recognize that change is inevitable. The decision one faces is do I wait and react to change or am I going to be proactive and inititiate change? One head nurse activity is strategic planning ensuring quality patient care in the future, which if followed through entails introducing change.

Planned change is a deliberate attempt to alter situations, practices, behaviors or attitudes. There are three sources for change. Origination is where the head nurse creates or invents the solution to a problem. Adaptation occurs when a solution developed elsewhere is modified and applied to the current situation. Borrowing is applying a predeveloped solution, with little or no modification, to the situation at hand.

Change should never be introduced for the sake of change itself. There should always be a good reason for change; to solve a problem inhibiting quality patient care, to increase work efficiency or to reduce costs. Effective change is planned and involves a change agent who is responsible for moving people through the change. Head nurses often take on the change agent role.

Kurt Lewin (1951) identified three phases contained in the change process, unfreezing, moving and refreezing. The first phase is unfreezing of the status quo or the current situation. The change agent gathers data, identifies the problem and the desired outcome, determines if change is really needed and makes others aware of the need for the change. The staff must believe in and be committed to the need for change in order for it to occur. Change is more acceptable when it is understood.

There are four strategies the head nurse can use to introduce the need for change to the staff. Rational-empirical strategies involve an unbiased presentation of the facts, both positive and negative aspects. The staff is assumed to be rational and will support the change given the facts. An example is: given the facts the unit is short staffed, the patient census highly variable and quality care is desired the staff will be supportive of a schedule change that includes staffing for the average census and placing nurses on call to cover the rare high census shifts.

The second strategy is persuasion where the head nurse gives a biased presentation of the information and focuses on selling the staff on the need for change. An example is: although the unit is short staffed the head nurse wants to give people their hard earned days off. Because the census has recently been at 40-60% capacity she/he would like to staff at that rate which allows for days off and vacations. However there are rare occasions when the census is at 75-90% of capacity. Since this staff is known for its professionalism and dedication to quality patient care the head nurse is sure the staff won't mind rotating call on days off. They will be called infrequently and the quality of patient care plus the unit's reputation will continue to be outstanding.

The third strategy that can be incorporated in change introduction is normative-reeducative. A group is used to socialize and influence others in the need for change. The focus is to establish the change as the norm. An example is: the head nurse identifies the informal leadership on the unit and convinces them the change is important in providing quality patient care. These informal leaders introduce the change to the staff, influencing them that it is the right thing to do.

The final strategy for change introduction is coercion. The head nurse uses power to force the staff to change. An example is the head nurse tells the assistant if the change is not supported enthusiastically the assistant will be considered to be undermining the head nurse's authority and someone else, who loyal and supportive will be found for the position. The head nurse can also call a staff meeting, present a schedule incorporating the call procedure, state this is how it is and if anyone fails to follow this directive they will be considered insubordinate and disciplinary action taken as required.

Once change is introduced and the unfreezing process is accomplished the second phase of change occurs. Moving involves the specification of goals and objectives regarding the change. It also includes identifying areas of support (driving forces) and of resistance (resisting forces). Lewin proposed using a force field analysis to facilitate the change process.

First the current situation or status quo is defined and the desired outcome specified. Second restraining forces, those issues likely to hamper or impede change are identified. Then the driving forces, those issues likely to facilitate the change are identified. To increase the chance of successful change implementation the head nurse needs to decrease the resisting forces, increase the driving forces or both. Strategies regarding the alteration of forces are developed and implemented resulting in the desired outcome or goal.

Strategies include involving everyone in the planning that will be affected by the change to increase their commitment. Target dates and responsibilities for planning and implementation activities need to be established. The change is implemented on a trial basis for a specific period, then it is evaluated. The change is maintained, revised or terminated. Refreezing occurs after evaluation indicates the desired outcome is present.

Lewin's third phase in the change process is refreezing. The change agent assists in stabilizing the change and integrating it into the status quo. The staff is supported and rewarded in their efforts to change.

Inservices on the change helps personnel realize the change is expected to be permanent. Writing policies or procedures regarding the change also help integrate the change into the system.

Delegation

Effective delegation is an essential skill for head nurses. It involves entrusting your power to another to do a task you would otherwise do yourself (Jenks & Kelly, 1985). Head nurses are then freed from doing and thus are able to perform their primary job of managing. Delegating is accomplishing objectives through others. It is a way to maximize the use of staff member's talents giving them opportunities to grow making yourself dispensable so that you can be promoted. Delegation closes the gap between staff and management.

It is a staff development tool. Delegatees are accountable as they practice problem-solving, decision-making and leadership skills in a safe environment. The head nurse assists by coaching, directing, evaluating and counseling, not by planning or doing. Delegation can also increase a head nurse's influence and power by increasing the amount of work that can be accomplished.

Head nurses sometimes hesitate to delegate. History shows promotions to head nurse have traditionally been based on one's proficiency at performing patient care skills regardless of management knowledge or ability. Moving from staff performance to delegating activities can be very difficult especially when the staff are former peers. Other reasons or excuses (Jenks & Kelly, 1985) for not delegating include the following:

- I can do it better and faster myself.
- I am afraid the staff may fail at the task.
- I want the credit.
- I enjoy doing the work.
- I want to keep up my skills.
- I don't want to appear bossy.
- I don't want the staff to do anything I wouldn't do.
- The staff are already over worked.

The signs a head nurse may be delegating poorly include (Jenks & Kelly, 1985) a heavy workload with no time available for vacations or outside activities, taking work home most nights, leaving tasks unfinished or not meeting deadlines, crisis management due to no time for planning, feeling overworked, rarely seeking staff opinions, feelings that the staff is coasting, staff members who won't make a decision without the head nurses input and there is no one on the staff who could be your likely successor.

Delegation is based on trust and a positive attitude toward the staff and their abilities. Effective delegation

requires planning. The task to be done is precisely defined, the required skills and educational level needed are identified along with best individual for the job in terms of abilities and time available. The head nurse must also consider the staff's needs for growth and development.

The watchword is delegate, don't dump. Delegate (Jenks & Kelly, 1985) routine matters (inventories), necessities (QA), trivia (explain what is wrong to the plumber), tasks requiring specialized skills and pet projects (you love working with computers and the unit's getting one, if the set up and programming isn't delegated you won't have time for management activities). Don't delegate ritual (don't put a staff nurse on a committee that's routinely composed of head nurses) and tasks related to the head nurse position such as policy making, specific personnel matters (praise-discipline), crises or confidential matters.

Responsibility is delegated but not 100%, as the head nurse you have ultimate responsibility. Delegate enough authority to enable the task's achievement. Communicate to the delegatee exactly what the task is, the purpose and objectives, resources available and any limitations or restrictions imposed.

Plan controls and establish deadlines to check on the delegatee's progress at periodic intervals. Controls should be based on outcomes not means. Let the delegatee plan and do. Avoid having the task delegated back to you with such phrases as "I agree that's difficult, think about it and let me know Friday what your recommendations or decisions are. Once the task is completed the head nurse takes blame for failures and credits the delegatee for successes. This fosters a willingness to try, risk-taking, and motivation in the staff supporting job satisfaction.

Negotiation

Negotiation is a process of resolving differences through discussion, getting what you want, while loosing as little as possible and making the other party feel satisfied with the outcome. The overall objective is obtaining a collaborative agreement.

There are three elements (Kelly, 1981) involved in negotiations. Process activities are the behaviors, strategies and tactics used such as threats, force, pay-offs, kickbacks, persuasion, compromise and mutual agreement.

Structure involves the interacting parties, the power balance, the environmental setting (comfortable, convenient, neutral), the presence or absence of an audience plus the norms, ethics and standards utilized.

The third element is the situation itself. This includes the number and complexity of the issues in addition to the number and experiences of the negotiators.

Negotiations must be carefully prepared with the head nurse gathering as much data as possible about the issues. Knowledge is power. Information about the opponents needs, arguments, deadlines and pressures is sought. Identify and prioritize the number of variables for potential concession points.

Know what your bottom line is, what you will and will not concede. Develop an alternative option for negotiation. An example is the goal for your unit is for staff nurses to provide more direct patient care. You would like an additional 4 RNs, 2 LPNs and a unit clerk. Your bottom line is 3 RNS and 1 LPN. The alternative option is brought out when it looks as if your bottom line won't be achieved. The alternative is then negotiated in lieu of the original option? Your option is to implement a unit dose medication system and have some of the nursing staff's current duties transferred to dietary and housekeeping personnel.

Head nurses need to understand negotiation is a psychological process as well as a verbal-information process. The effective negotiator looks calm and self assured. The desire to win may involve the us of psychological tactics (Marquis & Huston, 1987, 273-276).

- ridicule: undermines psychological space and demoralizes.
- smoke screen: confuses the opponent, often ambiguous or inappropriate questions are asked.
- over the barrel: the opponent uses one's weaknesses such as crying anger or cussing against them.
- seduction: conning the opponent; creating expectations of something good in the future.
- flattery: used to divert attention from the issue.
- sex: some women use their femininity to appear a push over or soft and fragile, then pounce on the opponent.
- helplessness/illness: since nurturing is a part of nursing a display of helplessness or a hint of illness often brings out the nurse negotiator's impulse to help; often to their own detriment.
- guilt: one opponent tries to make the other feel guilty ie. if you really cared about your staff you'd ... or if your goal is really quality care you'd ...
- definition: may be used to justify one's behavior; I'm really emotional justifies a latter crying jag or angry outburst. One may be defined by their opponent such as your the most flexible person I know. This statement makes other behavior difficult.

- paternalism: an I know what is best for you attitude.
- gifts: used to gain a power advantage. I gave you something in the past now you owe me.
- aggressive take-over: often occurs in committees where one member takes over, summarizes the discussion, makes a decision and adjourns the meeting without getting any input and before anyone realized what happened. It takes very assertive behavior to reopen the discussion and many groups don't bother.

A head nurse can use the following guideline (Keiser, 1988) to promote effective negotiations.

- Use open honest assertive communication and I messages.
- Acknowledge the opponent's views with grace.
- Listen to your opponent even when being attacked.
- Assert your own needs.
- Use clear concise clarifying questions.
- Anticipate the opponent's questions and prepare answers.
- Use only factual statements you've verified.
- Observe nonverbal communication and monitor your own? Remember eye contact decreases with fear or anxiety, blinking increases with stress and tension, foot jiggling may mean impatience, arm pinching indicated insecurity or uncertainty, while touching the face or ear is a hint of concealed information or lying.
- Keep an open mind during discussions, don't prejudge.
- Avoid blaming the opponent for the situation.
- Avoid making the first concession.
- Start high, concede low, always getting something in return of equal value and try never to use your bottom line.
- Restate the compromise making sure all parties agree on the solution, then follow-up the negotiations by sending a letter confirming the agreement.
- Try to end the negotiations on friendly terms. You may have to work with or negotiate with the individual again.

Negotiation skills are essential for successful head nurses. They can be used to obtain resources for your patient care unit or for resolving conflict.

Force Field Analysis Exercise

Each group will construct a force field analysis to aid with change using one of the following situations. Identify the status quo, the desired outcome, the restraining and the driving forces. Uses as many of your own assumptions as required.

1. Ted has had high blood pressure for three months and last week was put on medication therapy. He is 5' 10" tall and weighs 246 pounds. He is an insurance agent and rents a first floor apartment.

2. Anne is head nurse of a medical unit that has been selected for piloting computers at the bedside. The staff has mixed feelings. Anne considers herself computer illiterate. Joe the evening clerk is a university junior majoring in computer science.

3. Bob is the charge nurse for surgery in a small rural hospital. Recent patient surveys indicate the public desires an ambulatory surgery unit. The surgeons don't care. The nursing staff is supportive, but would need to be increased by three RNs.

Suggested transparences

Directing = accomplishing work through others

Power is influencing

Sources of Power

* Reward
* Coercive
* Legitimate
* Referent
* Expert
* Personnel

(Marriner-Tomy, 1988)

Power Uses

- Exploitation
- Manipulation
- Nurturing
- Integrative
- Competitive

(Levenstein, 1981)

Power Builders

- Skills: decision-making, leadership, political, communication, conflict resolution, entrepreneurship
- Recognize one's leadership power and strength
- Recognize one's power deficiencies
- Build a support system
- Nonverbal communication
- Act impeccably
- Know institutional power holders

(Courtade, 1978)

Lewin's Three Phases of Change

Unfreezing

Moving

Refreezing

(Lewin, 1951)

Delegate:

* Routine matters
* Necessities
* Trivia
* Tasks requiring special skills
* Pet projects

Don't delegate:

* Ritual
* Position related tasks
* Policy making
* Specific personnel matters
* Crisis
* Confidential matters

(Jenks & Kelly, 1985)

Negotiation Elements

Process

Structure

Situation

(Kelly, 1981)

Plan Negotiations

- Gather data
- Identify concession points
- Identify bottom line
- Develop an alternative option

Psychological Tactics

- Ridicule
- Smoke screen
- Over the barrel
- Seduction
- Sex
- Helplessness/illness
- Guilt
- Definition
- Paternalism
- Gifts
- Aggressive take-over

(Marquis & Huston, 1987)

Guides to Effective Negotiations

- Communication
- Acknowledge
- Listen
- Assertion
- Question
- Anticipate
- Use facts
- Observe
- Open-minded
- Don't blame
- Concession
- Start high
- Avoid the bottom line
- Time out

(Keiser, 1988)

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Controlling

Objectives

The participant will be able to:

A. Identify for standard establishment
B. Construct structure, process and outcome standards
C. Identify barriers to effective quality assurance
D. Identify the importance of peer review
E. Identify difficulties in implementing peer review
F. Discuss variance analysis
G. Design a plan for product purchasing

Teaching helps

A. Suggestions for student involvement
    1. Review of directing session, successes and failures with theory implementation
    2. Questions for discussion: What do you think about peer review as an evaluation technique? Have you ever felt overwhelmed when planning for the purchase of equipment such as monitoring systems, autoclaves or beds?
B. Lecture with transparencies
C. Final evaluation

Content

A. Definition and introduction
B. Quality Assurance
    1. Standards
    2. Barriers to effective quality assurance
    3. Peer review
C. Budget as control
    1. Budget analysis and variances
    2. Cost containment

Controlling

Definition and introduction

Head nurses are responsible for monitoring the quality of the services rendered to patients for their area of responsibility. They are also partly responsible for patient outcomes. Head nurses should be monitoring expenses, supply utilization and the unit's progress towards its goals.

Control is an on-going process. Actual performance is compared with preestablished standards, significant deviations are investigated and corrective action taken. Results are recorded and reported. Controls help assure no major unexpected event occurs.

Professional standards, codes of conduct, policies and procedures are control measures. They set the guidelines to be followed. Orientation, training and inservices provide controls in demonstrating how procedures are expected to be done in a particular institution. Control efforts should be aimed at correction, redirection, learning and growth, not critism and punishment.

It is also important to monitor the patient unit goals and objectives. This aid in focusing some activity onto goal achievement? Staff morale may be boosted knowing their work efforts produced desired results.

Quality assurance

Quality assurance (QA) activities ensure resolution of real and potential problems regarding patient care. QA activities are grounded in standards. These are descriptive statements of a desired level of performance. Head nurses are responsible fo developing standards specific to their unit. Standards are derived from national and state taxes, licensing and accreditation agencies (JCAHO) and inspection agencies (AF-HSMI) plus recommended standards of practice established professional organizations.

Standards are developed to improve the quality of patient care, to decrease the cost of patient care and to establish a basis for nursing practice negligence or excellence. There are three types of standards (Peter, 1977).

Structural standards define the purpose, legal authority, relationships, worker qualifications and the physical facilities. Two examples are: there will be 1 RN per 4 patients and all personnel at X hospital will be BCLS certified.

Process standards define methods for patient care written in behavioral terms. Examples are the nurse will assess recovery room patients at least every five minutes

and the nurse will change IV sites every 72 hours and document the site's appearance in the chart.

Outcome standards define methods for evaluating the results of patient care interventions. For example the patient verbalizes or demonstrates how to .... after receiving preoperative teaching.

Standards are incorporated into monitoring devices or audits. Three kinds of audits; structure, process and outcome which correspond with the three types of standards. Each type of audit may be done retrospectively, after the patient is discharged or concurrently while the patient is receiving care. For audits to be effective or useful the evaluation criteria must be explicit and determined prior to the audit. There also needs to be a valid method for data collection. When criteria are not met there must be a plan for corrective action. If deficiencies are not going to be corrected there is no need to do an audit.

The head nurse needs to identify obstacles to effective QA activities and plan to over come them. Some obstacles are (adapted from Gilles, 1882 & Marquis & Huston, 1987).

1. Using only retrospective audits which is a system to learn from mistakes rather than being proactive and prevent mistakes.
2. Minimal requirement attitude is the acceptance of mediocrity versus striving for excellence, being satisfied with accomplishing standards at their minimal levels.
3. Accepting errors in performance, often because they are so frequently seen, instead of investigating the cause treating only the affect.
4. Over dependence on current systems of care often related to a resistance to change.
5. Fragmentation of responsibilities and accountabilities resulting in assumptions someone else will do it or that not my problem attitudes.
6. Relationship breakdowns due to master-servant attitudes and poor communication, rather than stressing collaboration and team-building.
7. Concealment of mishaps or incidents often due to their being seen as a means of punishment rather than as learning opportunities for the improvement of patient care.
8. Greater concern about liability than quality.
9. Rigid inflexible bureaucratic behaviors and activities.

To off-set these obstacles the head nurse can use the following principles in preparing and applying proper controls. Controls should (Marquis & Huston, 1987, p. 298):

- be tailored to specific patient units, plans and objectives.

- be monitored to identify deviations early and at critical points.
- be objective.
- be flexible.
- fit the culture of the organization.
- be economical.
- lead to appropriate corrective action.

In carrying out QA activities the nurse manager needs to seek input from the patient population. Patients may not have the technical back ground to assess their professional care, but only the patient can judge whether comfort, privacy, friendliness, courtesy and personalized care were received. These items impact on the patient's perception of the quality of care received.

Finally QA activities include identifying, documenting and reporting problem trends in manufactured products such as sterile products that become contaminated upon opening. If every tenth foley catheter cannot be used and is thrown out a lot of money is being thrown out also. Reporting problems to the manufacturer may lead to improved products and also may lead to reimbursements for defective material bought.

Peer review

Another control the head nurse is involved with is employee evaluations. They provide feedback to staff members about their practice. Evaluation processes encourage managers to observe the staff's practice, identifies staff development needs, uncovers hidden talents, reduces unfairness in promotions and provides for monitoring of standards.

Peer review is one form of evaluation. It helps identify nursing as a profession that is self-regulating. Most professions have traditionally used peer review programs (Marquis & Huston, 1987), p. 326). This process involves staff nurses having input into the evaluation process; evaluating the performance of their peer's professional practice. Peer review may be incorporated into the evaluation process with the full program consisting of peer review, self-evaluation, supervisor's evaluation, and patient input or peer review may be the only form of evaluation.

The following difficulties may be encountered with the implementation of peer review (Marquis & Huston, 1985, p. 327).

- Poor orientation of the staff to peer review methods and tools resulting in feelings of threat and anxiety.
- Peers feeling uncomfortable with sharing feedback or suggestions omit critical and needed suggestions for improvement.

- Peer friendships can lead to unintentionally inflated evaluations.
- Supervisors may feel their control over staff performance is threatened, thus they resist this process.

To overcome these potential difficulties peer review programs must encompass the following (Marquis & Huston, 1985, p. 326):

- Develop appraisal tools that have standard based criteria.
- Thoroughly orient the staff to the peer review process and methods using literature reviews and change theory.
- Use information gathered from many sources (self, supervisor, peers, patients, charting, visitors) for the "official" evaluation.
- Incorporate a mechanism for anonymous feedback to promote evaluation rather than advocacy.

Peer review is time consuming, involves risk-taking and requires energy; however it remains the most effective means for a profession to increase it's autonomy and accountability.

Budget as a control

The budget is both a planning and a control device. This presentation will focus on the control aspect of budgeting. With the current emphasis on cost containment and fiscal responsibility it is essential head nurses develop expertise in managing and understanding costs. Fiscal control is the tracking of expenditures and income. Controls help keep the budget on track and goal focused.

Every organization has established budgeting procedures. It is the head nurses responsibility to understand these procedures, seeking consultation as required. Budget report often received by head nurses include capital budget and supply inventories, position controls plus monthly and quarterly cost center reports.

Budget analysis is an on-going process for the avoidance of major discrepancies between monies allocated and monies spent. Head nurses are accountable for budget deviation, both over and under expenditures. Thus budget reports must be reviewed as soon as they are received for variance identification. Variances are then analyzed to determine the cause and corrective action required. Variances should be briefly documented for reports to the chief nurse and or fiscal/resource management office.

As head nurses you must also be aware that deviations can occur between services rendered and reimbursements. Good documentation aids in ensuring the patient care unit and the institution obtains the maximum reimbursement that they are entitled to.

Under the DRG system for an item to be coded as an active problem it must be documented. For example (Hines, 1988) an IV infiltrates. The only documentation is in the nurses notes. Infiltrations can be coded as a complication of medical care and in many cases will boost the patient into a more intensive DRG, that may result in several thousand additional dollars in reimbursement. Too many times seemingly minor issues are not documented and thousands of dollars are lost. Accurate documentation can thus reduce the gaps between income (reimbursements) and expenses.

Cost containment

Costs must be controlled. Cost effectiveness does not mean cheap, it does mean getting the most for your money or ensuring a product is worth the price. Planning for product equipment purchasing will prove cost effective, keeping the budget in control, preventing excess expenditures.

The purchasing process (Baird, 1988) is similar to the nursing process and incorporates assessment, planning, implementation and evaluation. Assessment involves identification and analysis of the problem or need for a purchase, such as inadequacy of the current produce, new technology or cost reduction. Some questions to be answered are: What is the purpose of the desired product? What is the expected annual usage? Has it been used effectively else where? Will it increase revenue, effectiveness or efficiency? Will liabilities be involved? Will facility alteration be required? What is the maintenance and warranty specifications? Where can the equipment be bought, including repair parts? Will training be required, who will do it? What is the dollar cost?

Planning is the next stage involving investigation of available products on the market. Literature is reviewed, manufacturers talked with and institutions where the product is in use contacted by phone and or by a personal visit. Other departments input may be sought, such as biomedical, plant management and infection control.

The third stage involves implementation of a clinical trial of the product. An evaluation tool is developed specific to the desired product ie. instillation, training and maintenance costs; length and coverage of warranty; ease of handling and cleaning. The same criteria are used to evaluate all trial products.

The final stage incorporated evaluation of each trial product for the specified period of time. The results of the evaluation tools are tabulated and a purchasing recommendation made. All personnel who will use the item should have the opportunity to evaluate it.

This discussion ends the management workshop. We have looked at decision-making, and the management functions of planning, organizing, staffing, directing and controlling. I would like to thank you all for attending and ask that you take a few minutes to fill out the evaluation form.

Suggested Transparencies

Control = 1. Setting standards

2. Comparing performance to standards

Three Types of standards

* Structure
* Process
* Outcome

(Peter, 1977)

Obstacles to Effective QA

- Only retrospective audits
- Minimal requirement attitude
- Error acceptance
- Fragmentation
- Relationship breakdowns
- Concealment
- Liability concern
- Rigidity

(adapted from Gilles, 1982 & Marquis & Huston, 1987)

Controls Should:

- be specific
- be monitored
- be objective
- be flexible
- be economical
- fit the culture
- lead to action

(Marquis & Huston, 1987)

Implementation Difficulties

* Poor staff orientation
* Uncomfortable sharing
* Peer friendships
* Supervisor threatened

(Marquis & Huston, 1987)

Budget as a Control

Purchasing process = Nursing process

* Assessment
* Planning
* Implementation
* Evaluation

(Baird, 1988)

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Evaluation Form

Please rate the following statements on a scale of 1 to 5 with 1 being low and 5 being high. Check the appropriate number.

	1.	2.	3.	4.	5.
To what extent were the objectives met?					
a. Decision making					
b. Planning					
c. Organizing					
d. Staffing					
e. Directing					
f. Controlling					
To what extent was your knowledge increased?					
a. Decision making					
b. Planning					
c. Organizing					
d. Staffing					
e. Directing					
f. Controlling					
Was the content organized?					
a. Decision making					
b. Planning					
c. Organizing					
d. Staffing					
e. Directing					
f. Controlling					

Please answer the following questions.
Were your personal objectives met?

Yes_____ No_____If no please explain.

Was sufficient time allowed for each session?

Yes_____ NO_____ If no please explain.

Were your questions answered adequately?

Yes_____ No_____ If no please explain.

Were the facilities appropriate?

Yes_____ No_____ If no please explain.

Additional comments.

Suggestions for future workshops.